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SPECIALIZED CARE INCREMENT RATES

Los Angeles County, specialized care increment (SCI) rates are referred to as “D-Rate” or “F-Rate”. D-Rate refers to the supplemental rate paid in addition to the basic (“B-Rate”) rate for the care of a youngster with exceptional mental health and/or behavioral needs (see pages 5-18). The D-rate is one flat rate determined by the youngster’s age. The F-Rate refers to the supplemental rate paid in addition to the basic rate for the care of a youngster with exceptional medical and/or developmental needs. The F-Rate has four incremental levels and is determined by the youngster’s age and degree of impairment (see pages 19-63).

The following is an explanation of the criteria and methodology used to determine the increment at each payment level, a description of the qualifying factors at each level, the rate of each payment level and the forms used for SCI approval or denial.

All children in need of out-of-home care are to be placed in the least restrictive, most family-like setting consistent with their best interests and special needs. When children require a specialized foster family home, the assessment process, and placement selection must consider the possible impact of placement on the child and his or her overall needs, ability to transfer attachments, and need for continuity of care and supervision. To the maximum extent possible, DCFS places children that have special needs with relatives, non-related extended family members or in foster family homes within the child’s school of original attendance area. Children with special needs shall be placed with their siblings whenever possible.

For recipients of both the state- and federally-funded Kin-GAP Programs: The SCI is a rate based on our county’s approved Specialized Care Rate (SCR) Plan and is available to the relative caregiver or relative guardian once DCFS determines that the assessed child meets the SCI criteria of that Plan. The SCI can be increased or decreased as the special needs of the child change consistent with our approved county SCR Plan. If the relative guardian resides outside the county with payment responsibility, the county with payment responsibility pays the host county’s specialized care rate or its own specialized care rate if the host county has no specialized care system.

To Enrich Lives Through Effective and Caring Service

Note: If a child meets the criteria for SCI rate eligibility, the child may receive the SCI rate upon re-assessment indicating eligibility even though he or she did not receive the rate prior to entering Kin-GAP.

CAPACITY IN FOSTER CARE

It is DCFS' policy that an out-of-home caregiver may not have more than TWO children receiving, needing, qualifying for, or eligible to receive a specialized care rate, regardless of their licensed capacity. More will be considered only if the children were in the home prior to November 1, 1995, or child receiving the basic rate in a home is later assessed as needing specialized care and a determination is made that the child should remain in that home (this determination should take into consideration the impact on the child at issue as well as other children placed in the home), or when placement will keep siblings together and it is not clinically contraindicated. Verification of these requirements must be documented in the Case Notes. Placement of a third child with or without special needs **requires ARA approval**. Notwithstanding placement issues, any child that appears to need a specialized care rate should be assessed.

NOTE: When seeking ARA approval for the placement of a 3rd child, CSWs shall consider ALL children in the home, including birth, adopted, relative and guardian and not just the foster care placements

CAREGIVER'S REQUIREMENTS AND EXPECTATIONS

Foster parents, most relatives, non-related legal guardians, Kin-GAP legal guardians and non-relative extended family members are eligible to receive an SCI rate on behalf of a child.

NOTE: Children residing in Foster Family Agency (FFA) certified homes are not eligible for a specialized care increment. However, as part of the permanency planning for children residing in FFA certified homes, and who are potentially eligible for a specialized care increment, the CSW shall refer them for evaluation at the time of the Concurrent Planning Permanency Planning/Adoption Assessment. Having a recent assessment will assist in determining the appropriate Adoption Assistance Payment (AAP) and expedite the finalization of the adoption.

Per WIC 11461(e), the SCI shall not be paid to a nonminor dependent placed in a supervised independent living setting. "Supervised independent living setting" means, on and after January 1, 2012, a supervised setting, as specified in a nonminor dependent's transitional independent living case plan, in which the youth is living independently.

A child shall **NOT** be in a placement wherein the caregiver can not meet the child's special needs. Basic AFDC-FC funds are for the daily supervision, care, food, clothing, shelter, school supplies, the child's personal incidentals, liability insurance with respect to a child, and other expenses mentioned below. The SCI rate is paid for the extra care and supervision required for a child with special needs.

BASIC RATE – SCHEDULE “B” (includes relative caregivers and Nonrelative Extended Family member caregivers)

BASIC RATE		
AGE	Effective May 1, 2011	Effective July 1, 2011
0-4	\$609.00	\$621
5-8	\$660.00	\$673
9-11	\$695.00	\$708
12-14	\$727.00	\$741
15 – 18 + *	\$761.00	\$776

SPECIALIZED CARE INCREMENT (SCI) – D-RATE

AGE	BASIC RATE		SCI	SPECIALIZED RATE	
	Effective May 1, 2011	Effective July 1, 2011		Effective May 1, 2011	Effective July 1, 2011
0-4	\$609.00	\$621	\$776.00	\$1385.00	\$1397.00
5-8	\$660.00	\$673	\$714.00	\$1374.00	\$1387.00
9-11	\$695.00	\$708	\$663.00	\$1358.00	\$1371.00
12-14	\$727.00	\$741	\$615.00	\$1342.00	\$1356.00
15 – 18 +	\$761.00	\$776	\$562.00	\$1323.00	\$1338.00

SPECIALIZED CARE INCREMENT (SCI) – F-RATE

F-1

BASIC RATE			SPECIALIZED RATE		
AGE	Effective May 1, 2011	Effective July 1, 2011	SCI	Effective May 1, 2011	Effective July 1, 2011
0-4	\$609.00	\$621	\$369.00	\$978.00	\$990.00
5-8	\$660.00	\$673	\$303.00	\$963.00	\$976.00
9-11	\$695.00	\$708	\$254.00	\$949.00	\$962.00
12-14	\$727.00	\$741	\$206.00	\$933.00	\$947.00
15 – 18 +	\$761.00	\$776	\$150.00	\$911.00	\$926.00

F-2

BASIC RATE			SPECIALIZED RATE		
AGE	Effective May 1, 2011	Effective July 1, 2011	SCI	Effective May 1, 2011	Effective July 1, 2011
0-4	\$609.00	\$621	\$515.00	\$1124.00	\$1136.00
5-8	\$660.00	\$673	\$452.00	\$1112.00	\$1125.00
9-11	\$695.00	\$708	\$401.00	\$1096.00	\$1109.00
12-14	\$727.00	\$741	\$354.00	\$1081.00	\$1095.00
15 – 18 +	\$761.00	\$776	\$297.00	\$1058.00	\$1073.00

F-3

BASIC RATE			SPECIALIZED RATE		
AGE	Effective May 1, 2011	Effective July 1, 2011	SCI	Effective May 1, 2011	Effective July 1, 2011
0-4	\$609.00	\$621	\$776.0 0	\$1385.00	\$1397.00
5-8	\$660.00	\$673	\$714.0 0	\$1374.00	\$1387.00
9-11	\$695.00	\$708	\$663.0 0	\$1358.00	\$1371.00
12-14	\$727.00	\$741	\$615.0 0	\$1342.00	\$1356.00
15 – 18 +	\$761.00	\$776	\$562.0 0	\$1323.00	\$1338.00

F-4

BASIC RATE			SPECIALIZED RATE		
AGE	Effective May 1, 2011	Effective July 1, 2011	SCI	Effective May 1, 2011	Effective July 1, 2011
0-4	\$609.00	\$621	\$998.00	\$1607.00	\$1619.00
5-8	\$660.00	\$673	\$932.00	\$1592.00	\$1605.00
9-11	\$695.00	\$708	\$883.00	\$1578.00	\$1591.00
12-14	\$727.00	\$741	\$837.00	\$1564.00	\$1578.00
15 – 18	\$761.00	\$776	\$777.00	\$1538.00	\$1553.00

D-RATE

CHILD'S ASSESSMENT/DIAGNOSIS

Based on the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (currently DSM IV TR), a child must be diagnosed with behavior(s) inappropriate to the child's developmental age that impairs the child in critical life areas. The assessment must be made by a licensed mental health professional (LCSW, licensed MFT, Psychologist, Psychiatrist.) The diagnosis must indicate the child displays psychotic features, is a suicide risk or at risk of violence, or has substantial impairment in at least two of the following areas:

- ☐ Self-care
- ☐ School functioning
- ☐ Family relationships, and/or
- ☐ Functioning in the community

And either:

- ☐ The child is at risk of removal from the current placement or has already been removed, or
- ☐ The impairments have been present for six months or are likely to continue for more than one year without treatment.

NOTE: SSI screening is required for all youth 16 ½ years old. For all children receiving Regional Center services, assess if they qualify for the dual agency rate in lieu of a SCI rate. A child found by the Regional Center to not meet the criteria, under the Lanterman Act, to receive Regional Center services, may have a diagnosis of a Pervasive Developmental Disorder which falls under the "autism spectrum disorders" (e.g. Asperger's Disorder, Rhett Syndrome, Childhood Disintegrative Disorder (CDD) and Pervasive Development Disorder (NOS). As with any situations wherein there are medical or developmental concerns, CSWs shall consult with the PHN regarding these children to determine if a referral for a F-rate eligibility is warranted. If the child has emotional or behavioral issues, the PHN shall recommend that the CSW refer the child to the D-rate Evaluator to assess if the child qualifies for a D-rate or if the child warrants an increased F-rate level.

CAREGIVERS OF CHILDREN WHO HAVE BEEN DIAGNOSED AS REQUIRING SPECIALIZED CARE FOR EMOTIONAL/BEHAVIORAL PROBLEMS MUST MEET A. AND B. BELOW:

Prior to placing or replacing a child with an emotional or mental health needs/condition, CSWs shall ensure, in consultation with the D-rate Clinical Evaluator that the prospective caregiver is able and trained to meet the child's medical or mental health

needs. For children already in placement, CSWs shall continuously evaluate and assess, as part of their on-going duty, the child's safety and needs, quality of care received and the appropriateness of the placement. Child's safety should be the foremost consideration when evaluating the appropriate placement.

A.

- Have the training, education and/or skills necessary to ensure that they meet the special needs of the child and provide safety and quality of care in placement. This includes the 16 hours of initial D-rate certification training and 18 hours yearly thereafter to be certified. If the specialized training is not available (summer break, etc.), the training is to be completed within three (3) months of the next training.

NOTE: If the child is found to be eligible for the D-rate when placed in a home with a caregiver who has not received the above D-rate training, but the CSW believes the caregiver has the requisite knowledge, training, education or ability to meet the child's special needs, the caregiver requirement described in A. above is strongly recommended but not required for D-rate eligibility.

The CSW and the D-rate Coordinator, shall document in the case the basis for their conclusion that the caregiver possesses the requisite knowledge, training, education or ability to meet the child's needs, if the caregiver is relieved from D-rate training requirements.

B.

- Participate in the child's treatment including family counseling.
- Provide transportation to various facilities and providers.
- Provide social and recreational activities consistent with the child's needs.
- Familiarize themselves about special education and the Individualized Education Plan (IEP) process. Caregivers should advocate for the child's educational needs and rights by partnering with teachers.
- Learn daily interaction skills in meeting the child's particular needs and avail themselves of support groups and foster parent associations in developing support techniques.

CRITERIA FOR CHILD

Must meet all of the following:

- ❑ Child is between the ages of 5-18 years old. Children ages 37 months to 59 months may be referred with ARA approval. Youth 18 and over receiving the D-rate may continue to receive the rate, if otherwise eligible and meet continued AFDC-FC funding criteria.

NOTE: For dependent youth not eligible for AFDC-FC funding, DCFS will review the totality of the circumstances, including the existence of other state assistance, family assistance and other variables to determine that GRI (and the appropriate rate) is necessary and/or applicable, in the best interest of the child, placed in out-of-home care.

- ❑ The children reveal disturbances or behaviors, which are characterized by varying degrees of personality disorganization and departures from normal modes of thinking, feeling, perceiving and acting. They often exhibit impairment in reality testing, judgment and communication; and react to daily living experiences and rituals with excessive fearfulness, aggression, depression or withdrawal. Outbursts of rage, excessive verbal and physical aggressiveness, including overt and covert hostility, are common.
- ❑ Suicidal ideation and/or attempts are not uncommon. The children respond with extreme impulsivity and assume rigid postures of fight or flight when frustrated. They employ a deeply ingrained maladaptive constellation of behaviors, which are hostile, provocative, distrustful, manipulative, defiant or vengeful. Their behaviors place them in chronic conflict with parents, teachers, peers and society at large.
- ❑ The volatile, unpredictable, destructive, and antisocial qualities of their behavior trigger much concern about the danger to self, others and/or property. Diagnostic impressions may vary but most often revolve around psychosis, borderline conditions, severe personality and character disorders, and unsocialized aggressive reactions.
- ❑ Placement histories of these children generally reveal rejection, placement disruptions, prior hospital commitments, and multiple replacements. They are extremely difficult to live with because of their chronic unmanageable and unsocialized behaviors. Likewise, educational inventories frequently reveal major learning deficits consistent with the cycle of rejection, disruptions and replacements. These children are often known to school personnel and are portrayed as “unwanted” by school districts because of their acting-out behavior.

- ❑ Child has a current (i.e. within the past 12 months) clinical evaluation, including a Multidisciplinary Assessment Team (MAT) assessment, supporting D-rate eligibility or is receiving SSI for emotional needs.
- ❑ Children being placed in a D-rate home from a RCL 12 or above facility (including psychiatric hospitals) can be presumed eligible from the date of placement. If a child is already receiving SSI for psychiatric reasons, the child should be referred for D-rate.

D RATE PROCESS

In most cases, the initial assessment referral is made by the CSW. After processing of the referral, the initial assessments are completed by the Department of Mental Health (DMH). The D-rate is effective only as long as the need exists and the goal is to provide services and treatment to resolve the child's mental health needs. DMH contracts with private providers (psychologists) to go to the home and assess the child and the situation. MAT assessments conducted within one year of the initial D-rate referral or clinical assessments performed by licensed mental health professionals and conducted within one year of the initial D-rate referral, may be considered by DCFS in lieu of the DMH assessments conducted by DMH contracted D-rate Assessors.

The D-rate Section was operationalized to achieve two goals:

- Assist the case-carrying CSW with the formulation of a viable case plan that will meet the child's specialized and specific needs, including three (3) to five (5) goals to be attained within the next six month period. This goal includes the provision of resources, community support and linkages and brokerages to comprehensive and innovative mental health services. Included in this paradigm are individual, group and family therapy, in-home therapy, case management, respite care, educational linkages, brokerage with Regional Centers, community social and recreational resources, TBS/one-on-one support and health care resources, and
- Work with D-rate foster caregivers to help them achieve better outcomes with their children and addressing their needs and concerns. These would include direct access to a knowledgeable, clinical D-rate Evaluator who can address their concerns, including process concerns, the need for resources, services and supports outlined above and methods helpful in dealing with this high-end population.

DCFS D-rate Evaluator CSW IIIs, are assigned to regional offices to serve D-rate children. They are supervised by Licensed Supervising Children's Social Workers and team with DMH Medical Case Workers and a Supervising Psychiatric Social Worker. Each child's case is reviewed/recertified annually to evaluate progress, re-assess goals and modify treatment options as indicated.

A team composed of the CSW, D-rate Evaluator, DMH Medical Caseworker and ideally other persons involved in the child's treatment plan (caregiver, child, teacher, doctor, etc.) develop a plan to determine the appropriate foster home, related requirements and expectations of the caregiver and treatment modalities responsive to the results of the D-rate assessment. The team also formulates a viable case plan to meet the child's specific needs including the three to five goals to be attained within the next year. The CSW's case plan must be suitable with this plan.

Procedures

A. WHEN: INITIATING A D-RATE ASSESSMENT

CSW Responsibilities

1. Within one business day of notification or observing that the child may have an emotional/behavioral problem, discuss with the caregiver the child's emotional/behavioral problem(s) and the related activities needed to determine and meet the needs of the child. See the Operational Sections under Caregiver Requirements and Expectation and Caregivers of Children Who Have Been Diagnosed As Requiring Specialized Care for Emotional/Behavioral Problems of this Procedural Guide, for more details.
2. Complete the following D-rate packet of forms:
 - DCFS 417, Schedule "D" Caregiver Referral
 - DCFS 1695, D-Rate Indicators and Child Referral
 - If the child has had a mental health assessment (DSM diagnosis included) within the past year by a LCSW or licensed mental health professional or a MAT Summary of Findings (SOF) report, include a copy along with the required forms.

NOTE: ARA approval is required when requesting an assessment for any child age 37-59 months or when placing a third child receiving a specialized rate in the home.

3. Forward the D-rate packet to the SCSW for review of the documentation to initiate a D-rate assessment.

SCSW Responsibilities

1. Within one business day of receiving the packet, review all documentation.
 - a) If approved, sign necessary documents and return to the CSW.
 - i) When the D-rate assessment is for a child 37-59 months of age, and/or when there is a capacity issue, forward the packet to the ARA for approval.

ARA Responsibilities

1. Within one business day of receiving the packet, review all documentation.
 - a) If approved, sign necessary documents and return to the SCSW.
 - b) If not approved, return for corrective action.

CSW Responsibilities

1. Upon approval from the SCSW and/or ARA for a D-rate assessment, forward the packet to the office's D-rate Evaluator.

D-RATE Evaluator Responsibilities

1. Receive and log the packet on the "D-Rate Referral Log".
2. Review the documentation and complete the following:

If the packet includes a mental health or MAT assessment, including a DSM diagnosis and indication the caregivers are able to meet the child's needs, completed within the past year, and the documentation indicates the child's condition(s) warrant the D-rate, complete the D-rate Evaluator's portion of the DCFS 1695, forward to the D-rate Section supervisor for approval and proceed to step 3.

If the documentation requires an assessment of the child, forward the packet to DMH.

Upon receipt of DMH's assessment, complete the D-rate Evaluator's portion of the DCFS 1695 indicating the approval or denial of the D-rate, forward to the D-rate Section supervisor for approval and proceed to step 3.

3. Attend the regional Team Decision meeting to develop the goals for the next year, return the CSW's original D-rate assessment packet, and discuss with the CSW the results of the assessment. Ensure that the child is linked to any services needed to address his or her emotional/behavioral needs. If the child is not linked, consult with the DMH Medical Case Worker or the DMH co-located Specialized Foster Care staff regarding linkage.
4. If available, obtain a copy of the D-rate training certificate from the caregiver and file with the D-rate packet. Also annotate the DCFS 1695:

If the caregiver has not attended the D-rate training, recommend to the caregiver that the training be completed within three months of the placement. If it is determined that training or services are not necessary as the caregiver possesses the requisite knowledge, training, education or ability to meet the special needs of the child, the D-rate Coordinator and CSW shall document in the case the basis for their conclusion regarding why the caregiver may be relieved from the D-rate training requirements.

- b) If it is determined that the training and or services are necessary to meet the child's needs and caregiver refuses to complete or has not followed through with the required services and/or training, inform the caregiver that you will be making a recommendation as to the appropriateness of the placement and as necessary the course of action to be taken.
 - c) Consult with the CSW, SCSW and ARA to assess the child's safety in placement and determine if court involvement is necessary. Consult with the handling County Counsel, if necessary. Determine if the CSW should seek court involvement depending on the level of risk in existence (court involvement includes but, is not limited to court orders for cooperation with training to mitigate marginal care leading to safety risks or, depending on a placement change, seeking a removal order due to immediate safety concerns.)
5. File a copy of the D-rate packet and all supporting documents in the designated "D-rate Section" office file.

CSW Responsibilities

1. Within one business day of receiving the packet from the D-rate Evaluator approving the D-rate, submit the DCFS 1695 to the SCSW and/or ARA for signature.
2. Within one business day of receiving the packet from the D-rate evaluator determining the child is not eligible for the D-rate, notify the caregiver that the D-rate was denied. Inform the caregiver that a Notice of Action (NOA) will be mailed with instructions on how to appeal the decision.

3. If it is determined that court involvement is necessary, CSW should immediately determine the next hearing date and, if not immediate, seek a walk on request, to ensure that the issue is raised and addressed by the court. Contact and inform the handling County Counsel regarding the review and level of risk the child is exposed to.

SCSW Responsibilities

1. Within one business day of receiving the DCFS 1695, review, complete and sign and return to the CSW.

NOTE: When there is a capacity or age issue, forward the documents to the ARA for approval.
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CSW Responsibilities

1. File documentation in appropriate case folders.

B. WHEN: THE ANNUAL D-RATE ALERT IS RECEIVED

The D-rate will expire at the end of 12 months unless another assessment is completed and determines the D-rate shall continue. It is the team's responsibility to determine the three of five outcomes/ performance goals upon which the D-rate and concurrent treatment is developed.

CSW Responsibilities

1. Upon receipt of the annual alert, if it is believed that the D-rate should continue, follow steps set forth in Part A.

D-RATE Section Staff Responsibilities

1. Upon receipt of the reassessment request from the CSW, follow steps set forth above in Part A, beginning with the heading *D-RATE SECTION*.

SCHEDULE "D" CAREGIVER REFERRAL**Submit completed form to D-Rate Clinical Evaluator stationed in your regional office.**

Child's _____ Date of Birth _____ S. S. #: _____

Foster Caregiver's Status: Complete all areas and check all applicable boxes.

☐ Relative ☐ Licensed Foster Parent☐ Non-Related Extended Family Member

License Number

Name _____ Email _____

Address _____

Phone _____

Numbers: Home: _____ Cell: _____

Ensure that the following statements are true and verify by marking a check on each line after discussing with caregiver. If an item is not applicable, enter N/A

1. If licensed, this caregiver(s) has been a foster parent at least two years.* ☐
2. Caregiver(s) has demonstrated the parenting skills necessary to care for emotionally disturbed children. ☐
3. Caregiver(s) is knowledgeable and willing to cooperate with services providers and community resources. ☐
4. Caregiver(s) has experience with special education and is willing to be an educational advocate for special needs children. ☐
5. Caregiver(s) is able to cope with emergencies and crisis situations. ☐
6. Caregiver(s) has good problem solving skills. ☐
7. Caregiver(s) works well with the child's parents. ☐
8. Caregiver(s) is willing to attend the 16 hour initial certification specialized caregiver training and the 18-hour specialized D-Rate renewal training annually. ☐
9. Caregiver(s) is willing to participate in the treatment of the child, including being involved in family counseling when deemed appropriate by the case plan. ☐
10. Caregiver(s) will provide social and recreational activities for special needs children. ☐
11. This home is a safe and appropriate environment for this special needs child. ☐

12. Indicate the total number of children residing in the home, including birth, adopted, relative and guardian and not just the foster care placements. Indicate the total number of children residing in the home receiving the: Basic Rate: ; D-Rate: ; F1: ; F-2 : ; F-3: ; F-4: ; Regional Center Rate: ; Regional Center Rate with supplemental rate:

If the caregiver has not been licensed for two years, s(he) must be successfully caring for a child with emotional/behavioral problems and/or have employment experience with this population.

The above listed statements have been discussed with me and I understand and agree to comply with them.

Caregiver's Signature Date

Caregiver's Signature Date

This referral was reviewed and discussed with the CSW. This home is approved to care for

CSW Signature Date

SCSW's Signature Date

CSW's Tele. #: _____

SCSW's Tele. #: _____

D RATE INDICATORS AND CHILD REFERRAL FORM

For children with severe emotional and/or behavioral problems

Child's Name: _____ Date Completed: _____ ☐ Initial ☐ Reassessment
 DOB: _____ Social Security No.: _____ Date of Initial Detention: _____
 CSW: _____ File No.: _____ Case No.: _____
 Phone No.: _____ E-mail: _____ Office: _____
 D Rate CSW: _____ Medical Case Worker (DMH): _____
 Caregiver's Name: _____ Home Phone: _____ Cell Phone: _____
 Relationship to Child: _____ Caregiver's Email Address: _____
 Caregiver's Address: _____
 Funding Type: ☐ Foster Care/Youakim ☐ AAP ☐ CalWORKs/TANF (AFDC) ☐ SSI ☐ None
☐ FFA Rate (under AAP child can qualify for a specialized care rate) ☐ KinGAP
 Current rate: ☐ Basic Rate ☐ D rate ☐ F1 rate ☐ F2 rate ☐ F3 rate ☐ F4 rate
☐ Regional Center/ARM rate: \$ _____

Age of Child: _____ - Children can qualify for D rate if they are ☐ 5-18 or ☐ 3-4 (37-59 months) with ARA approval
 - Children under 3 years old are not eligible for the D rate – refer child to Regional Center Early Intervention Program and/or infant mental health services

Part I

1. <input type="checkbox"/>	Child has had psychological/psychiatric evaluation by: (attach copy of evaluation) <input type="checkbox"/> DMH <input type="checkbox"/> Other (please check one): <input type="checkbox"/> Licensed psychologist <input type="checkbox"/> Licensed psychiatrist <input type="checkbox"/> LCSW <input type="checkbox"/> Licensed MFT Name and Title of Evaluator: _____ Evaluation Date: _____
2. <input type="checkbox"/>	Child is in therapy. Indicate the type of therapy and frequency below Date therapy began: _____ Therapist's Name: _____ Type of License or License #: _____ Phone: _____ <input type="checkbox"/> Individual _____ times per week <input type="checkbox"/> Group _____ times per week times per month _____ times per month <input type="checkbox"/> Family _____ times per week <input type="checkbox"/> Behavioral therapy _____ times per week times per month _____ times per month
3. <input type="checkbox"/>	List any mental health diagnosis (include date of diagnosis).
4. <input type="checkbox"/>	List any medication child takes for emotional/behavioral condition(s) (include dosage if available). 1. _____ 2. _____ 3. _____ <input type="checkbox"/> Child is prescribed medication, but not taking it. Please explain. <input type="checkbox"/> Psychotropic medication authorization (PMA) is on file, dated _____
5. <input type="checkbox"/>	Other supportive services the child receives. List type and frequency of service below. <input type="checkbox"/> TBS (Therapeutic Behavioral Services): _____ <input type="checkbox"/> Behavioral Therapy: _____ <input type="checkbox"/> Other (list type and frequency): _____ If any boxes in Part 1 are checked and child is <u>not</u> receiving the D rate, discuss with your d rate worker

Part II

For Sections 6 – 20, check all boxes that apply. Please provide additional information on the lines provided and attach additional pages if needed. When describing the child's behavior, please include information about the severity, frequency and duration of the behavior.

6. <input type="checkbox"/>	Child not in therapy, but caregiver thinks child would benefit from therapy/has requested referrals for therapy. Describe concerns of caregiver/reasons caregiver believes child needs therapy. List any referrals that have been made.
7. <input type="checkbox"/>	Child having serious problems at school with: <input type="checkbox"/> behavior <input type="checkbox"/> attention/focusing <input type="checkbox"/> social skills <input type="checkbox"/> truancy <input type="checkbox"/> suspensions <input type="checkbox"/> aggression/fighting
8. <input type="checkbox"/>	<input type="checkbox"/> Child has IEP for special education Date of last IEP _____ <input type="checkbox"/> Due to emotional/behavioral problems that prevent child from learning. <input type="checkbox"/> Due to emotional/behavioral problems that prevent child from learning IEP included referral for AB3632 evaluation for mental health services. <input type="checkbox"/> Needs IEP <input type="checkbox"/> needs referral for AB 3632 evaluation.
9. <input type="checkbox"/>	History of: <input type="checkbox"/> Physical abuse <input type="checkbox"/> Emotional abuse <input type="checkbox"/> Sexual abuse <input type="checkbox"/> Neglect <input type="checkbox"/> Gang Affiliation <input type="checkbox"/> Criminal history <input type="checkbox"/> Substance abuse <input type="checkbox"/> Domestic violence in the home <input type="checkbox"/> Other:
10. <input type="checkbox"/>	Family history of substance abuse/mental illness (list diagnosis if known) <input type="checkbox"/> Birth Mother _____ <input type="checkbox"/> Birth Father _____ <input type="checkbox"/> Other Relatives (specify): _____
11. <input type="checkbox"/>	Placement history reveals <input type="checkbox"/> Multiple placements/ disruptions List types: _____ <input type="checkbox"/> Psychiatric hospitalizations <input type="checkbox"/> Group home/ residential setting (level 12-14)/ Community Treatment Facility (CTF) <input type="checkbox"/> State Hospital
12. <input type="checkbox"/>	Child exhibits significant changes in behavior and/or severe behavior problems with: <input type="checkbox"/> Eating/appetite <input type="checkbox"/> Play/ recreation <input type="checkbox"/> School performance <input type="checkbox"/> Sexual activity (not age appropriate) <input type="checkbox"/> Sleeping/ nightmares/ night terrors <input type="checkbox"/> Appearance <input type="checkbox"/> Sexually provocative <input type="checkbox"/> Uses drugs or alcohol <input type="checkbox"/> Overweight <input type="checkbox"/> Headaches <input type="checkbox"/> Nervous movement or twitching State below when changes began and if changes can be attributed to a specific incident or traumatic event

13. <input type="checkbox"/>	Enuresis/ bed wetting — Not age appropriate and not caused by a medical problem.
14. <input type="checkbox"/>	Encopresis/ smearing — Not age appropriate and not caused by a medical problem.
15. <input type="checkbox"/>	Child does not know: (consider age of child and whether most children that age would know this information) <input type="checkbox"/> Date <input type="checkbox"/> Time <input type="checkbox"/> Place <input type="checkbox"/> Other _____ <input type="checkbox"/> Child sees things that aren't there. <input type="checkbox"/> Child hears things that aren't there.
16. <input type="checkbox"/>	Child consistently: <input type="checkbox"/> Uses poor judgment <input type="checkbox"/> Does not act in socially appropriate ways <input type="checkbox"/> Has poor impulse control <input type="checkbox"/> Focuses on certain thoughts <input type="checkbox"/> Boasts or shows off <input type="checkbox"/> Has problems concentrating <input type="checkbox"/> Is easily distracted
17. <input type="checkbox"/>	Child exhibits excessive <input type="checkbox"/> Fearfulness <input type="checkbox"/> Withdrawal <input type="checkbox"/> Depression/ tearfulness <input type="checkbox"/> Avoidance of eye contact <input type="checkbox"/> Physical activity <input type="checkbox"/> Outbursts of rage <input type="checkbox"/> Unpredictable/ volatile behavior <input type="checkbox"/> Physical and/or verbal aggression <input type="checkbox"/> Feels worthless <input type="checkbox"/> Anxious <input type="checkbox"/> Does not seem guilty when misbehaves
18. <input type="checkbox"/>	Displays behaviors which are: <input type="checkbox"/> Overtly/covertly hostile <input type="checkbox"/> Anger provoking in others <input type="checkbox"/> Distrustful <input type="checkbox"/> Manipulative <input type="checkbox"/> Excessively defiant <input type="checkbox"/> Vengeful <input type="checkbox"/> Dishonest <input type="checkbox"/> Steals
19. <input type="checkbox"/>	Chronic conflict with: (check appropriate boxes and describe on the lines provided) <input type="checkbox"/> Caregiver(s) <input type="checkbox"/> Peers <input type="checkbox"/> Teachers <input type="checkbox"/> Birth parent(s) <input type="checkbox"/> _____
20. <input type="checkbox"/>	Danger to/destructive to: (check appropriate boxes and describe on the lines provided) <input type="checkbox"/> Self _____ <input type="checkbox"/> Suicidal ideation/verbalization and/ or attempts <input type="checkbox"/> Others (list) _____ <input type="checkbox"/> Homicidal <input type="checkbox"/> Pets/ animals _____ <input type="checkbox"/> Property _____
If multiple boxes in the left-hand column in sections 6-20 are checked and child is not receiving the d rate, discuss with your d rate worker	

Actions To Be Taken

Part III

This section to be filled out by the CSW/SCSW/ARA

- ☐ Refer child for D rate assessment
 ☐ CSW to initiate referral for D rate training for caregiver immediately.
- ☐ Request D rate for child (child has already had psychological/psychiatric evaluation, has severe emotional behavioral problems and is in therapy and/or on medication).
 Please attach documentation.
- ☐ Refer child for IEP evaluation for special education services.
 ☐ IEP referral to include request for child to be referred for AB 3632 evaluation for mental health services
- ☐ Child's current rate seems appropriate
- ☐ Refer child for additional services (list)

Signature of CSW: _____

Date: _____

Signature of SCSW: _____

Date: _____

Signature of ARA: _____

Date: _____

This Section to be filled out by the Office of the D-Rate Section

☐ D Rate of \$. approved Effective: _____

☐ D Rate Denied. Explain:

D Rate Evaluator / Lic. _____

Date: _____

D Rate Section Supervisor / Lic. _____

Date: _____

Additional comments about the child's behavior/condition. Scroll down or attach additional pages if necessary.

F-RATE

Children with special health care needs can often live in foster care homes providing the foster parents and assistant caregivers are trained by health care professionals pursuant to the health care plan or discharge plan of the facility releasing the child being placed in, or currently in, foster care. Additional training shall be provided as needed during the placement of the child and to the child's biological parent or parents when the child is being reunified with his or her family. Foster parents who are licensed health care professionals are exempt from this requirement.

Each child must have a customized individualized health plan, developed by a team of individuals personally involved in the child's well being. The health care team shall delineate and coordinate health and related services for the child and the appropriate number of hours to be provided by any health care professional designated to monitor the child's individualized health care plan. The plan may also include the identification of any available and funded medical services that are to be provided to the child in the home, including, but not limited to, assistance from registered nurses, licensed vocational nurses, public health nurses, physical therapists, and respite care workers. The plan must reflect what specific activities are required to improve the child's functioning and how the F-rate will support these goals. This documentation must include the diagnosis, prognosis, treatment and medically related activities to be performed by the caregiver. The child's eligibility for SSI, due to a medical condition, is based on the Social Security Administrations' guidelines and determination.

The child's case plan must be congruent with the individualized health care plan. This includes referring the child for an Individual Education Plan (IEP).

At the six-month reevaluation, if the child still requires the F-rate, the case plan must reflect any progress, or lack of, and any future goals/activities, if appropriate, to improve the child's functioning.

Dependent children of the court, requiring special health care for medical conditions, are eligible for the F-rate or the dual agency rate for dual agency children, provided that they are placed in a qualified placement and meet other criteria.

Medical conditions requiring specialized in-home health care includes, but are not limited to:

- Dependency on enteral feeding tube, total parenteral feeding, cardiorespiratory monitor, intravenous therapy, ventilator, oxygen support, urinary catheterization, renal dialysis, ministrations imposed by tracheostomy, colostomy, ileostomy, or other medical or surgical procedures, or special medication including ongoing regimen of injections, and intravenous medications.
- Other medical conditions considered for the F-rate include HIV/AIDS, premature birth, some congenital defects, severe seizure disorders, severe asthma, broncopulmonary dysplasia and severe gastroesophageal reflux.

CAREGIVERS OF CHILDREN ELIGIBLE FOR A F-RATE MUST MEET A. and B. below:

Prior to placing or replacing a child with medical needs/condition, CSWs shall ensure, in consultation with the Public Health Nurse that the prospective caregiver is able and trained to meet the child's medical or health care needs. See Procedural Guide 0600-513.10, Medical Case Management Services (MCMS): Intake /Transfer Criteria and Transfer Procedures. For children already in placement, CSWs shall continuously evaluate and assess, as part of their on-going duty, the child's safety and needs, quality of care received and the appropriateness of the placement. Child's safety should be the foremost consideration when evaluating the appropriate placement.

For placements in Los Angeles County:

A.

- Meet the appropriate and child-specific training requirements to ensure safety and quality of care in placement (DCFS requires that Legal Guardians, relatives, non-relative extended family members, and non-specialized foster parents must complete training as well). Child-specific training is mandatory for each child with special health care needs. **Note: As early as possible, CSWs shall notify the caregivers of this training requirement and if necessary, assist in facilitating the completion of this training.**

This includes the 16 hours of initial F-rate certification training and 12 hours yearly thereafter to be certified. If the specialized training is not available (summer break, etc.), the training is to be completed within three (3) months of the next training sessions.

NOTE: If the child is found to be eligible for the F-rate when placed in a home with a caregiver who has not received the above F-rate training, but the CSW, in consultation with the PHN, believes the caregiver has the requisite knowledge, training, education or ability to meet the child's special needs, the caregiver requirement described in A. above is strongly recommended but not required for F-rate eligibility. The PHN and the CSW shall document in the case the basis for their conclusion that the caregiver possesses the requisite knowledge, training, education or ability to meet the child's needs, if the caregiver is relieved from F-rate training requirements.

B.

- To participate in the child's treatment, which may include family counseling.
- Provide transportation to various facilities and providers.
- To provide social and recreational activities consistent with the child's needs.

DUAL AGENCY CHILDREN

The procedures in this Procedural Guide are **no** longer applicable for dual agency children as there is now an established process to receive the dual agency rate. However, a dual agency child 0 – 3 years old, receiving Early Start services but not yet determined to have a qualifying developmental disability is eligible for the dual agency rate of \$898.00/month. If the child also has a medical/physical condition determined to meet criteria for an F-2, F-3 or F-4 rate, the child can receive a higher rate through the SCI - F-rate. The caregiver shall be given the option of whether to receive the dual agency rate or the SCI F-rate. In these cases, CSWs shall collaborate with the Regional Center for the agency to determine as soon as possible if a child has a qualifying developmental disability and thereby would be eligible to receive the dual agency rate of \$2006/month, even prior to the child turning 3 years old.

If the caregiver opts to receive the F-rate in lieu of the dual agency rate of \$898.00/month, then these procedures shall still be followed. CSWs shall ensure that the F-rate is changed to the appropriate dual agency rate once child is determined to have a qualifying developmental disability or child turns three and determined to have a qualifying developmental disability.

WIC 11464 does **not** mandate that caregivers of dual agency children complete training in order to qualify to receive the Regional Center/dual agency rate when otherwise eligible for the rate. However, all children with medical/physical needs/condition, regardless of the type of funding or foster care rate, must be brought to the attention of the PHN for review and caregiver training recommendation. As stated above, all caregivers of children with special health care needs are **required** to complete any child-specific training as outlined in the child's Individualized Health Care Plan, physician's treatment plan and/or medical discharge plan. However, for dual agency children with special health care needs, the PHN shall make the appropriate recommendation on any additional caregiver training, such as the 16-hour F-rate training and/or renewal training.

CHILD'S ASSESSMENT/DIAGNOSIS

There are four levels to the F-rate, F1, F2, F3 and F4. RAs must approve F3 and F4 rates. The guidelines for determining the appropriate level are detailed in Attachment I. Details of required care for specific disorders are described in Attachment II. When a

child is receiving mental health services related and/or in addition to the medical condition, the F-rate is increased one level, not to exceed F-4.

A child found by the Regional Center to **not** meet the criteria, under the Lanterman Act, to receive Regional Center services, may have a diagnosis of a Pervasive Developmental Disorder which falls under the “autism spectrum disorders” {e.g. Asperger’s Disorder, Rhett Syndrome, Childhood Disintegrative Disorder (CDD) and Pervasive Development Disorder (NOS)}. As with any situations wherein there are medical or developmental concerns, CSWs shall consult with the PHN regarding these children to determine if a referral for a F-rate eligibility is warranted. If the child has emotional or behavioral issues, the PHN shall recommend that the CSW refer the child for a D-rate evaluation to assess if the child qualifies for a D-rate or if the child warrants an increased F-rate level. The CSW may refer the child for a D-rate evaluation, independent of the PHN, in any situation. .

The Public Health Nurse (PHN) shall determine the appropriate F-rate, based upon a complete and thorough assessment of the child’s medical record. Therefore, it is necessary for the CSW to provide the child medical record to the PHN as soon as possible. Documentation must be from a health care provider who has examined the child within the prior six months. The F–rate set by the PHN cannot be changed. If there is concern about the level, the worker should provide additional information to the PHN. Staff shall **not** provide a specific F-rate level or amount to a caregiver or prospective caregiver until a final evaluation has been completed by the PHN. Staff shall instead advise the caregiver of the child’s needs, condition, the process of the F-rate evaluation including at what point the case is in and as applicable, the training requirements.

Children receiving the F–rate must be reevaluated every six months. The F–rate is effective only as long as the need exists. At the time of reevaluation, documentation must be made of the need for continued care and compliance with the health care plan.

A. WHEN: ASSESSING THE NEED FOR “F-RATE”

CSW Responsibilities

1. Within one business day of notification or observing that the child may have a special health care need, discuss with the caregiver the child’s physical, neurological, and/or developmental disorders and the related activities needed in order to determine the needs of the child. It is highly recommended that the CSW and PHN make a joint visit to the caregiver’s home when assessing the child’s medical needs.

2. Provide the following F-rate packet:

- DCFS 149 Medical Care Assessment Cover Letter
 - DCFS 149A, Medical Care Assessment
 - DCFS 416, Individual Health Care Plan
 - DCFS 1696, F-Rate & Regional Center Rate Indicators
 - Copy of the caregiver's F-rate training certificate, if available
3. Forward the DCFS 149A to the appropriate California Children's Services (CCS) paneled and/or appropriate Pediatric Specialty treating physician(s) and request they complete the form and return it along with all available medical records documenting the child's status and needs.
4. Caregiver may also obtain a medical report on the physician's letterhead, prescription slip from the physician, in lieu of the 149A, as long as all the elements are included.
5. Information must include detailed diagnoses, prognoses, treatment plan, and the specific medically related activities to be performed by the caregiver.
6. Documentation must be current (within the past 6-months).
7. In collaboration with the PHN, determine the F-rate to be recommended by completing pages 2, 3 or 4 and "Actions to be Taken" section on page 6 of the DCFS 1696, using the medical/developmental documentation.
8. Locate the child's condition or the caregiver's activity by using the F-Rate Criteria Guidelines (Attachment I) and the Guide to F-Rate Criteria (Attachment II).
9. Place an X in the applicable boxes that correspond with the description of the required medical activities, infant behavior or Regional Center diagnosis.
10. The highest column level marked will be the F-rate paid for the child.
11. If the child also has documented severe emotional problems and is in a psychological treatment program raise the F-rate one level by placing an X in the column that is one level higher than the highest medically related level.
12. Within one business day of receiving the completed DCFS 149A and medical records, forward the packet to the PHN. If a copy of the caregiver's F-rate training certificate can not be included in the packet, notify the PHN whether or not the caregiver has completed the training and if not, whether or not the caregiver is willing to complete the training and if so, where the caregiver is in the process of completing the training or in providing verification of training completion and put this information in the corresponding section of the DCFS 1696. Forward a copy to the PHN as soon as possible in the course of the PHN making the F-rate assessment.

13. Within one business day of receiving the packet back from the PHN identifying the appropriate F-rate, take the following actions:

- a) If caregiver training verification has not been previously obtained and provided to the PHN, obtain as available, a copy of his or her training certificate. Forward a copy of the caregiver's training certificate(s) and the DCFS 1696 to the PHN for review.
- i) If the caregiver has not attended the F-rate training, advise the PHN that the F-rate training has not been completed by the caregiver.
- ii) Consult with the PHN and jointly make a determination if caregiver is able to meet the child's needs despite lack of the F-rate training.

NOTE: If the child is found to be eligible for the F-rate when placed in a home with a caregiver who has not received the above F-rate training, but the CSW, in consultation with the PHN, believes the caregiver has the requisite knowledge, training, education or ability to meet the child's special needs, the caregiver requirement described in A. above is strongly recommended but not required for F-rate eligibility. The PHN and the CSW shall document in the case the basis for their conclusion that the caregiver possesses the requisite knowledge, training, education or ability to meet the child's needs, if the caregiver is relieved from F-rate training requirements.

- iii) If in consultation with the PHN, it is determined that the training and/or services are necessary to meet the child's needs and caregiver refuses to complete or has not followed through with the required services and/or training, consult with the SCSW and/or ARA to assess child's safety in placement and determine the appropriate action (e. g. court involvement to seek a court order for cooperation and training to mitigate safety risk, or depending on the placement change, seek a removal and replacement order due to immediate safety concerns).
14. When the DCFS 1696 with the PHN's signature is received and as appropriate/available, training verification submit the signed DCFS 1696, medical documentation, copies of training certificate(s) and, if applicable, the psychological documentation to the SCSW for approval and if appropriate, submission to the ARA and RA. If the child is not on SSI, include the statement "Evaluate the child for SSI." Levels F-1 and F-2 **do not require** ARA approval but Levels F-3 and F-4 require RA approval.
15. File documentation in appropriate case folders.
16. Document all contacts with the caregiver and physician in the Contact Notebook.

17. Advise the caregiver that the F-rate will be reviewed every six months. The F-rate may also be reviewed between intervals if medical or psychological status changes.
18. If applicable, within one business day of receiving the packet from the PHN determining that the child is **not** eligible for the F-rate, inform the caregiver that a Notice of Action (NOA) will be mailed to him or her instructions on how to appeal the decision.
 - a) Submit a request that a NOA be mailed regarding the denial of the F-rate.

SCSW Responsibilities

1. Within one business day of receiving the packet, review all documentation including training verification, and:
 - a) If approved and the rate is F1 or F2 and there is no capacity issue, sign necessary documents and return to the CSW.
 - i) When there is a capacity issue or the rate is F3 or F4 forward the documents to the ARA.
 - b) If not approved, return packet for corrective action.

ARA Responsibilities

1. Within one business day of receiving the packet, review all documentation, and:
 - a) If approved, sign the necessary documents and return to the SCSW.
 - i) If the rate is for F3 or F4, forward the packet to the RA for approval.
 - b) If not approved, return the packet for corrective action.

RA Responsibilities

1. Within one business day of receiving the packet, review all documentation, and:
 - a) If approved, sign the necessary documents and return to the SCSW.
 - b) If not approved, return the packet for corrective action.

PHN Responsibilities

1. Within three business days of receiving the packet, review the documentation. If further information is needed, consult with the CSW. If the F-rate certificate is not in the packet and was not previously advised by the CSW of the reason, discuss

with the CSW about the any training the caregiver has received, training needs if any and how the caregiver is meeting the child's needs.

- a) If advised by the CSW and/or noted on the DCFS 1696 that the caregiver has not completed the F-rate training, indicate on the DCFS 1696 that the training certificate is not available/provided. Indicate that the F-rate training is strongly recommended (and any other additional training as applicable) in the PHN section of DCFS 1696 and proceed with completing the DCFS 1696 to determine the applicable F-rate level that the caregiver is eligible to receive.
2. Collaborate closely with the CSW. It is highly recommended that the PHN and CSW make a joint home visit in determining the appropriateness of the F-rate and the selected placement that best meets the needs of the child.

Assist the CSW in contacting the physician or any other applicable service provider if additional information is needed.

3. As available, review the available caregiver's training certificate(s) to verify current certification and complete DCFS 1696 as appropriate.
4. As soon as sufficient information is received, complete the PHN's section of the DCFS 1696, and return it with the medical documentation to the CSW.

B. WHEN: UPON THE RECEIPT OF THE SIX-MONTH F-RATE ALERT OF THE MANAGEMENT INFORMATION DIVISION (MIC)

Children receiving the F-rate must be reevaluated every six months. However, there may be cases where it is reasonably expected that the child's condition will change significantly prior to the sixth month re-evaluation. The CSW, in collaboration with the PHN, shall follow the steps in this section by the re-evaluation date noted on the DCFS 1696.

CSW Responsibilities

1. Collaborate closely with the PHN. It is highly recommended that the CSW make a joint home visit with the PHN in determining the appropriateness of the F-rate and the placement that best meets the needs of the child. Guide 0070-560.05, Joint Response Referral, for instructions.
2. Follows steps set forth above in Part A if it is believed that the F-rate should continue. At the review, continuing levels F-3 and F-4 need only ARA approval.
3. If the rate is to remain the same, the caregiver does not need to sign a new DCFS 1696.

4. Document all contacts with the caregiver in the Contact Notebook.

SCSW Responsibilities

1. Ensure that:
 - a) F-rates are completed in a timely manner.
 - b) F-rates are appropriate and consistent according to the special health care needs of the child as documented in the 1696.
2. Follow up on identified delinquent and inconsistent F-rates.

PHN Responsibilities

1. Ensure that:
 - a) F-rates are completed in a timely manner.
 - b) F-rates are appropriate and consistent according to the special health care needs of the child as documented in the 1696.
2. Follow up on identified delinquent and inconsistent F-rates.

F-RATE CRITERIA GUIDELINES

Children receiving F-rate must be reevaluated every six months. The review may result in a change in the F-rate status for the child, i.e., increase, decrease, or termination of payment. Forward the 149a to the appropriate CCS paneled and/or appropriate pediatric specialty treating physician(s) and request they complete the form and return it along with all available medical records documenting the child's status and needs.

1. ASSISTING WITH DAILY LIVING TASKS BEYOND LEVEL EXPECTED FOR CHILD'S AGE DUE TO SERIOUS MEDICAL PROBLEMS

ACTIVITY	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
A. Eating	Feeding 30-60 minutes due to serious medical problem for example: GERD	Feeding over 60 minutes due to medical problem	Intermittent G-tube feeding	Continuous G-tube feeding
	Supervised self-feeding due to medical problem	Caregiver feeding required due to medical problem Special diet requiring diet planning, special meal preparation, and monitoring child's response to food consumed (e.g. failure to thrive, kidney problems, diabetes)	Special feeding technique (e.g., cleft palate) Special diet requiring diet planning, special meal preparation, and monitoring child's response to food consumed where errors in diet could result in threat to life and/or mental functioning for example: metabolic diet, documented severe food allergy requiring EPHInephren-PEN	NG tube feeding Parenteral nutrition (IV or central venous line or PICC line- (Peripherally Inserted Central Catheter)

ACTIVITY	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
B. Hygiene	Age 4 -7: All basic bathing and dressing activities due to medical problem (e.g., neurological deficit) Non extensive cast care – 1 extremity	Age 8 or older: All basic bathing and dressing activities due to medical problem		
C. Elimination	Age 4 years + requiring assistance with toileting.	Age 4 years +: with no bladder and/or bowel control due to a medical problem	Child requires use of appliance (e.g. colostomy or ileostomy collection bags) added 8/18/09	Dialysis
D. Ambulation	Age 2 years + that requires prescribed orthopedic corrective devices, e.g. A.F.O's (ankle, foot orthotics) that are time limited.			Age 2 years +: Wheelchair, gurney, braces, walker. Any age with extensive casting.
E. Vision/ Hearing	Eye Prosthesis	Legally Blind Hearing impaired requiring the use of assistive devices to hear		Totally blind Profoundly deaf unable to hear with assistive devices, caregiver uses ASI for communication

2. ADMINISTERING MEDICAL OR DEVELOPMENTAL REGIMENS

ACTIVITY	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
A. Surgical/ Wound Care		Established cerebral shunt care	New or revised cerebral shunt care (first six months after insertion or revision)	
			Daily/frequent dressing utilizing sterile techniques (e.g., burns, large wounds)	Post-multistage surgical care (e.g., burn reconstruction, skin grafting)
		Established prosthetic for missing appendage	New prosthetic for missing appendage (first six months after surgery)	
B. Respiratory Care Asthma/respiratory Disease	As needed medication/treatment supervised by caregiver	Daily medication/treatment supervised by caregiver		
Other Chronic Respiratory Condition, e.g. Cystic Fibrosis		Postural drainage and percussion as needed up to three times per day	Postural drainage and percussion four times a day or more	
		Apnea and/or heart monitor (must be CPR trained)	Intermittent oxygen	Continuous oxygen Ventilator dependent

				Tracheostomy
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ACTIVITY	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
C. Diabetes		Oral hypoglycemic medications	All insulin dependent diabetics. Caregiver administration and/or supervision of insure regimen including blood sugar testing, diet management, etc.	Newly diagnosed, (within last six months)
D. Medical Treatment	Administration of topical medication for severe, chronic conditions, e.g. eczema	Administration of injectable medication for chronic conditions (lovenox, human growth home)	Caring for child with hemophilia requiring Factor 8	
E. Seizure Disorders # 2 On 1696	Controlled seizure disorder with medications			Seizure disorder NOT controlled by medication(s).
F. Developmental treatment	Prescribed developmental treatments provided by caregiver such as infant stimulation procedures, physical therapy, speech therapy, and occupational therapy See Attachment II for requirements			



3. MONITORING HEALTH STATUS OF CHILD

CONDITION	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
A. Potentially Life-Threatening Illnesses, non-communicable			<p>Documented remission of illness/disease, caregiver is responsible for regular monitoring due to higher risk of relapse.</p> <p>Caregiver administration and/or supervision of specific medications for potentially life threatening conditions, e.g. cardiac problems</p>	<p>Daily monitoring for signs of rejection, infection, bleeding, pain. e.g., organ transplant, aplastic anemia, immune deficiency disorder, cancer, leukemia, sickle cell disease. May also require reverse precautions</p>
B. Potentially life threatening illnesses, Communicable Disease	Prophylactic medications for TB		<p>Breakdown in universal precautions could cause caregiver death or infection with life-threatening illnesses (e.g., hepatitis B or C)</p> <p>Drug resistant conditions requiring strict adherence to medical regimen (e.g. MRSA, ORSA).</p>	HIV/AIDS positive blood test

4. CARING FOR INFANT PRENATALLY EXPOSED TO DRUGS OR ALCOHOL (MUST BE REFERRED TO REGIONAL CENTER)

CONDITION	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
<i>Infant behaviors which may be associated with Prenatal Drugs (e.g., arching, rigidity, irritability)</i>	Inconsolable crying and high-pitched screaming up to 6 hours per day	Inconsolable crying and high-pitched screaming up to 12 hours per day	Inconsolable crying and high-pitched screaming more than 12 hours per day	

5. CARING FOR CHILDREN WITH DEVELOPMENTAL DISABILITIES WHO HAVE BEEN DIAGNOSED/SERVED BY REGIONAL CENTER

CONDITION	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
Disabilities	Developmentally delayed (only for children under age three who are followed by Regional Center)			
	Mild mental retardation Epilepsy/seizure disorder Mild/moderate cerebral palsy	Moderate mental retardation Mild autism	Severe mental retardation Moderate autism Severe cerebral palsy which significantly impairs activity	Profound mental retardation Full-syndrome autism Severe cerebral palsy which precludes activity

6A. WORKING WITH A CHILD'S BEHAVIOR PROBLEMS IN CONJUNCTION WITH MEDICAL PROBLEMS

Caring for an infant or child with a medical problem is especially difficult when the child also has an emotional or behavioral problem which interferes with rendering prescribed medical care. To be considered in this category, the child must be age 3 or older, have a documented emotional/behavioral problem, and be enrolled in and attending a treatment program designed to address the emotional/behavioral problem diagnosed. This category was added to recognize the many challenges associated in caring for the medically-needy child with emotional/behavioral problems, and increases the F-rate by one level beyond the highest medically-related activity required to be delivered by the caregiver.

6B. WORKING WITH A CHILD WITH MULTIPLE MEDICAL PROBLEMS ADDED

When a child has multiple medical problems that require the caregiver to attend multiple appointments, administer multiple treatments, or visit multiple specialists, consideration may be given to increase the rate one level above the highest medically related caregiver activity up to level four. Specific caregiver tasks need to be documented by the health care provider(s).

GUIDE TO F-RATE CRITERIA

In using this guide, the determination of appropriate and fair reimbursement rates for those caring for children with medical problems is based upon the specific medically related activities that the caregiver must perform in caring for the child. As diseases may vary in their intensity from one child to another, the value of assessing the specific care that is required for each individual child allows a more objective measure in the determination of an appropriate rate of reimbursement.

The following information is to be used to supplement the F-Rate Criteria Procedural Guide and the F-Rate Documentation form. It is suggested that the CSW observe the activities that must be delivered by the caregiver. Consultation with the DCFS office PHN is encouraged.

1. ASSISTING WITH DAILY LIVING TASKS BEYOND THE LEVEL EXPECTED FOR CHILD'S AGE DUE TO A SERIOUS MEDICAL PROBLEM

Newborns and infants require caregivers to assist with all tasks that are necessary to sustain and enhance life. The caregiver must assume all responsibility for feeding, bathing, helping with ambulation, and dealing with the process of elimination. As children age and develop, they normally learn how to take over many of the activities of daily living functions a caregiver must perform during their early years. In some cases, a serious medical or developmental problem may impair a child's ability to learn or execute these tasks of daily living. When a child has a serious medical problem and a caregiver must perform activities that assume responsibility for daily living tasks beyond the level expected for the child's age, an F-rate reimbursement should be considered. A serious medical problem is defined (in this context) as a medical problem which:

- a. Lasts longer than two weeks.
- b. Requires a physician's intervention after diagnosis in order to treat the illness.
- c. Significantly impacts the level of care required to be delivered to the child by the caregiver.

A serious medical problem does not include common childhood illnesses that are acute in nature and limited in duration.

1-A EATING

Often children with medical problems or developmental delays have trouble taking in enough food to sustain life and promote growth. They may have trouble sucking, swallowing, chewing, or taking food to their mouth. Some children must have special diets where the food intake is measured in calories, fats, and proteins such as for a diabetic diet, or they must be monitored to safeguard against eating certain food substances that may cause an allergic or other life-threatening reaction.

Some feeding problems are common and should not be considered to be a problem warranting an F-rate. During feeding, newborns and young infants may become "fussy" after consuming just a few ounces of formula. This occurs because the child swallows air during feeding and needs to be burped. After burping, the child usually quiets down and resumes feeding. Whenever possible, the CSW should observe the feeding process to determine the approximate length of time and relative difficulty encountered. Questions concerning the feeding process and requirement for special techniques should be directed to the office PHN.

EATING - LEVEL 1

FEEDING 30-60 MINUTES: At this level, infants or children who take a longer than "normal" time to feed (30-60 minutes) due to a medical problem are considered. The most common medical problems that can prolong feeding times include prematurity, prenatal drug exposure, esophageal reflux, or neurological defects. Prematurity and prenatal drug exposure can cause the infant to be irritable, have poor sucking reflexes, and be overall "slow feeders." Eating problems associated with prenatal drug exposure and prematurity usually are self-limiting and resolve in a matter of months as the child grows and learns the eating process. Esophageal reflux, a condition where the child requires slow feedings with frequent burping and correct positioning to allow the food to move slowly down the digestive tract and not to be constantly regurgitated (vomited), is common in some diseases.

Some cases of esophageal reflux require surgical correction and some resolve on their own, depending upon the underlying medical problem. Neurological deficits such as cerebral palsy, stroke, and head trauma can affect the nerve process involved in sucking and swallowing.

SUPERVISED SELF-FEEDING: Also at this level are children who require supervised self-feeding due to medical problems. These children are at an age that usually requires minimal supervision to feed themselves without difficulty. Children who require caregiver assistance and supervision may have difficulty in eating due to neurological problems such as cerebral palsy or Down syndrome which may cause tongue thrust, poor lip closure, or abnormal gag and swallowing reflexes. The caregiver must monitor the child closely during feeding to prevent or treat choking.

EATING - LEVEL 2

FEEDING MORE THAN 60 MINUTES: At this level, infants or children who require over 60 minutes in order to take in an adequate amount of nutrients are considered. Any of the medical problems noted under 1-A, Level 1 also can result in "extremely" prolonged feeding times that last longer than one hour.

CAREGIVER FEEDING REQUIRED: Level 2 also considers the child who is old enough to self-feed, but is unable to do so because of a medical problem. This may be due to any of the previously mentioned neurological problems.

SPECIAL DIET: Included at Level 2 are those children who must have a special diet requiring special meal preparation and monitoring of their response to the food consumed e.g., failure to thrive. Most commonly, this involves the diabetic child who must maintain a strict diet and take insulin medication in order to adequately control the level of sugar in the blood. This category also includes those children who must limit their salt (sodium) intake due to heart problems or protein intake due to kidney problems.

FAILURE TO THRIVE: Activities involved at this level include caring for a failure-to-thrive child. A failure-to-thrive child may initially show signs of increased irritability during feedings and it is often difficult for the caregiver to ensure proper nutritional intake. A failure-to-thrive infant may arch his/her back, cry, refuse to suck from a bottle, and may even spit up food or formula that is placed in the mouth. Feeding difficulties with these children is usually time-limited and should disappear in a matter of months.

EATING - LEVEL 3

INTERMITTENT G-TUBE: Intermittent G-tube feedings mean that the child is fed a liquid diet through a tube that is surgically inserted directly into the stomach or intestine through the abdomen. Any of the previously mentioned medical problems can interfere with food intake to the point that this method of eating must be used to sustain the child's life. The caregiver must learn how to administer the tube feedings and monitor the child for possible aspiration (choking) that can occur if the fluid goes in too fast and backs up into the child's throat. Wound care around the site of the tube insertion into the stomach is required and it also may be necessary to prepare the child for possible future oral food intake (e.g., training the child to suck and receive oral stimulation by the use of a pacifier during the tube feedings).

SPECIAL FEEDING TECHNIQUES: Special feeding techniques that may be required to facilitate food intake are also considered at this level. Children who have cleft palates may require special feeding techniques (positioning, holding the jaw or cheeks during feeding) or equipment (e.g., special bottles and nipples) which enable them to suck and swallow without aspirating (inhaling) the formula. A cleft palate, or opening in the roof of the mouth that leads into the nasal cavity, makes it difficult to suck and swallow. Special nipples and feeding techniques are often used to feed the infant until surgery can be performed to close the opening. Special feeding techniques are usually taught by hospital nursing personnel, and the caregiver must spend a period of time at the hospital prior to the child's discharge to learn the proper feeding procedure.

SPECIAL DIET: Considered in Level 3 are those caregiver activities that require the preparation of special diets, strict diet planning, and close diet monitoring where errors in food intake could endanger the child's life. Very severe food allergies can result in anaphylaxis (a life-threatening allergic reaction requiring caregiver knowledge of the use of an EPINEPHRINE PEN) and may be difficult for the caregiver to prepare diets that are devoid of these substances. Examples are allergies associated with peanuts, shellfish, artificial colorings, and wheat or other grains that may be partial ingredients in many commonly eaten foods.

NOTE: This category does not include "intolerance" problems, such as "milk intolerance." Often wrongly called a "milk allergy," this problem is due to the child's inability to digest lactose (milk sugar) effectively, resulting in gastrointestinal problems such as gas or diarrhea. This problem is not "allergic" in origin, nor is it life-threatening. Milk intolerance problems can easily be avoided with the current market availability of soy-based (milk-free) infant formulas and "lactose free" or "lactose reduced" milk products.

Also considered in this category are those diets that must be planned and monitored to avoid foods that may cause severe mental retardation in children who have Phenylketonuria (PKU). Children with PKU lack the necessary enzyme needed to break down proteins found in meats, milks and cheeses. It is extremely difficult to prepare diets that supply an adequate amount of protein necessary for growth and development while avoiding animal proteins which the child cannot effectively metabolize.

EATING - LEVEL 4

CONTINUOUS G-TUBE FEEDINGS: Continuous G-tube feedings are considered at this level. G-tube feedings require that the child be fed on an almost continuous basis via an electrically powered pumping device (Kangaroo). As mentioned previously, a G-tube is a tube that is surgically inserted through the abdomen into the child's stomach or intestine. Continuous feedings are often done when the child cannot absorb large amounts of formula during one feeding, and instead must have a slow, continuous drip.

NG TUBE FEEDINGS: NG tube feedings require that the caregiver insert a tube through the child's nose and into the stomach for each feeding. This is required when the child is unable to suck or swallow adequately, but is expected to overcome the problem within a relatively short period of time. This technique requires that the caregiver learn the procedure (usually from hospital nursing personnel), and take great care to closely monitor the child before and after feedings. The potential of accidentally putting the tube and instilling the formula into the infant's lungs is always present.

PARENTERAL NUTRITION: Parenteral nutrition (total parenteral nutrition or “TPN”) is the instilling of a clear liquid (electrolyte) diet directly into the child's veins. This is done when the child's stomach and intestines are unable to tolerate, absorb, or digest formula feedings. An intravenous (IV) line (sometimes called a central line) is inserted into a major vein (usually inside the child's chest or neck) and a prescription “formula” is slowly infused by a pumping device. The risk of infection that can be life-threatening and dislodgment of the tube is very high in these children.

1-B HYGIENE

Caregivers who must perform activities related to the child's hygiene beyond the level expected for the child's age are included in this section. “Hygiene” refers to the activities that must be done to maintain body cleanliness and promote health. Included in hygiene activities are bathing, brushing teeth, dressing, and maintaining the cleanliness of the child's clothing and bedding.

HYGIENE - LEVEL 1

HYGIENE 4-7 YEARS, INCLUSIVE: This level involves hygiene activities that must be delivered to children between the ages of 4 through 7 years, inclusive. A child of this age should, under normal circumstances, be able to independently perform many of these activities, but is unable to do so due to a medical problem. Medical problems can include neurological deficits, injury or trauma. Casted extremities requiring the assistance of caregiver are to be included in this category.

HYGIENE - LEVEL 2

HYGIENE 8 YEARS OR OLDER: This level involves children age 8 or older who are unable to adequately perform hygiene activities on their own. The problems may be identical to those listed in Level 1, but due to the increased body size of the older child, the workload and activities of the caregiver are expected to be greater.

1-C ELIMINATION

Considered in this category are children with medical or developmental problems that are manifested by an inability to control bladder or bowel functions, or reliance on appliances to facilitate elimination.

ELIMINATION - LEVEL 1

4 YEARS OR OLDER AND NEEDS ASSISTANCE: Children 4 or older who need caregiver assistance with toileting due to medical problems are considered at this level. This *also* includes children who are nighttime bed-wetters (nocturnal enuresis) or who soil their beds with fecal matter (nocturnal encopresis). Nighttime bedwetting may be associated with neurological disorders, specific diseases, or a genetic tendency that runs in families.

ELIMINATION - LEVEL 2

4 YEARS OR OLDER WITH ENURESIS OR ENCOPRESIS: Children 4 or older who have no bladder and/or bowel control day and night due to a medical problem are considered at this level. Most likely, children who require this level of activity are those with severe neurological disorders.

ELIMINATION - LEVEL 3

INTERMITTENT CATHETERIZATION, COLOSTOMY, URETEROSTOMY: Children who require the use of appliances to facilitate the elimination of body wastes require this level of caregiver activity. The term "Appliances" refer to the tubes and bags that are used to collect wastes external to the body. The term "appliances" includes the use of catheters (tubes) that must be inserted by a caregiver into the bladder periodically to drain urine e.g. indwelling catheter; ureterostomy and ureteroileostomy appliances which are surgically implanted tubes that drain urine contents into a collection bag worn by the child; and, colostomy and ileostomy appliances, which are also surgically implanted tubes that drain to bags worn by the child to collect fecal matter. Surgically implanted tubes and their collection bags must be monitored closely for signs of internal infection, skin breakdown or erosion, and/or impaction or blockage. Wound care around the site of insertion must be done frequently, and the appliance must be changed when full or soiled.

ELIMINATION - LEVEL 4

DIALYSIS: Peritoneal or hemodialysis. Many children who have kidney disorders must receive dialysis to internally regulate the elimination of wastes from their body fluids. The child must be connected to a filtering (dialysis) machine via an intravenous (IV) route (i.e., "shunt") which is surgically implanted. Treatments are done daily or less frequently (every other day, every three days, etc.) in medical treatment centers, depending upon the severity of the child's medical condition. Some children may have devices that can be used at home during their sleeping hours. Children who require this level of care are usually candidates for kidney transplants. They are very prone to infection and must have their diet closely regulated. If a home dialysis device is to be used, the caregiver must receive intensive instruction in the use of this equipment.

1-D AMBULATION

The child who is over two years of age and whose ability to ambulate on his/her own is impaired due to medical problem is considered in this category.

AMBULATION - LEVEL 1

Age 2 years or over that require prescribed orthopedic corrective devices (e.g. A.F.O.'s - ankle, foot orthotics) that are time limited.

AMBULATION - LEVEL 4

NON-AMBULATORY: Care for any child age two or over who is non-ambulatory (unable to walk unassisted) is considered at Level 4. Children who are dependent upon a wheelchair, gurney, braces or walker for mobility.
Any age with extensive casting.

Note: A child who is unable to leave a burning building without assistance is considered non-ambulatory.

1-E VISION/HEARING

VISION HEARING LEVEL 1

Eye Prosthesis: Child has an eye prosthesis following an enucleation (removal of the eye) for any reason.

VISION/HEARING - LEVEL 2

VISION/HEARING - LEVEL 4

Totally blind or profoundly deaf and unable to hear with assistive devices.

Children who are totally blind are considered at this level.

Also considered at this level are the children who are profoundly deaf and are unable to hear even with the use of assistive devices. The caregiver is to communicate using American Sign Language (ASL).

2. ADMINISTERING MEDICAL OR DEVELOPMENTAL REGIMENS

This category includes performing medically related activities that are prescribed by a physician for the caregiver to perform. Caregivers who must deliver medical treatments and therapy in the home usually are instructed in the correct procedures by the hospital of discharge or by visiting home nurses. **It is required that the physician clearly indicate in writing the medical services to be delivered by the caregiver.**

2-A SURGICAL/WOUND CARE

Caregiver activities may be required (usually on a time-limited basis) to care for children who have undergone a trauma and/or surgery that requires extensive wound care. In most cases, the caregiver must be trained by hospital medical staff in the proper wound care procedures to be followed.

SURGICAL/WOUND CARE - LEVEL 2

ESTABLISHED CEREBRAL SHUNT CARE: At this level, children with cerebral (brain) shunts are considered. An established cerebral shunt is one that has been in place for more than six months. Cerebral shunts are tubes that are inserted into brain cavities (ventricles) to drain excess levels of fluid that accumulate. The tubes usually drain into the abdomen or major blood vessels internal to the child. Cerebral shunts are used in children who are termed hydrocephalic (“water on the brain”). Hydrocephalus can be congenital (present at birth) or caused by disease, meningitis (infection in the lining of the brain), trauma or stroke. The caregiver must be knowledgeable concerning the signs of an increased intracranial pressure (irritability, high-pitched crying, seizures, etc.) which could indicate a tube blockage or infection.

ESTABLISHED PROSTHETIC FOR MISSING APPENDAGE: Caring for the child who has prosthetic devices (artificial limbs) to replace a missing appendage also falls under this level of care activities. The caregiver usually must work with the child in both physical and occupational therapy in addition to dealing with the psychological issues involved.

SURGICAL/WOUND CARE - LEVEL 3

NEW OR REVISED CEREBRAL SHUNT CARE: First Six Months After Insertion or Revision). At this level are those caregiver activities necessary to care for a child with a newly inserted (first 6 months) cerebral shunt. As mentioned under Level 2, a cerebral shunt drains excess fluid from the brain. During the post-operative period immediately following the shunt placement and for approximately the first six months, the caregiver must closely observe the child for signs of internal infection or tube blockage. The caregiver must be knowledgeable concerning the signs of an increased

intracranial pressure (irritability, high-pitched crying, seizures, etc.) which could indicate a tube blockage. Cerebral shunts have to be replaced periodically as the child grows, and the risk of blockage, infection, and malfunction is higher during the post-operative period.

DAILY/FREQUENT DRESSING CHANGES: Utilizing Sterile Technique (e.g. burns, large wounds). Also considered at this level are the caregiver activities that involve daily or frequent (2-3 times/week) wound dressing changes utilizing sterile techniques. Commonly, this type of care involves children who have been burned, have large open wounds. These conditions are usually time-limited, and the child would be expected to recover in a matter of months. Sterile techniques involve the use of sterilized bandages, sterile gloves, germicidal soap washes, and topical antibiotic ointments to avoid infection at the wound site.

NEW PROSTHETIC FOR MISSING APPENDAGE (First Six Months After Surgery): Caring for a child who has a new prosthetic device (first six months after surgery) to replace a missing appendage is considered at this level. In addition to working with the child in both physical and occupational therapy and dealing with the psychological issues involved, the caregiver must provide wound care for the stump.

SURGICAL / WOUND CARE LEVEL 4

POST-MULTISTAGE SURGICAL CARE (e.g. Burn Reconstruction, *skin grafting*): Considered at Level 4—are similar wound care activities outlined above at Level 3—At this level, more extensive wound care is required to be performed by the caregiver. This type of wound care is often required for extensive burn reconstruction.

2-B RESPIRATORY CARE

Care requirements for children who have respiratory disease vary considerably according to the child's diagnosis and the severity of the illness. Some children with respiratory problems that manifest early in their lives, such as bronchopulmonary dysplasia (BPD), may have few or no symptoms once they grow in body and lung size, and their lungs mature. Other children may have respiratory illnesses such as asthma that exacerbate (get worse) during certain seasons of the year but remain trouble-free for most of the year. The CSW must work closely with the caregiver and the physician to ascertain the respiratory care needs of the child in relation to his/her illness.

It is important that children with asthma live in smoke free homes.

ASTHMA / RESPIRATORY DISEASE - LEVEL 1

Administration of as needed medications: Treatment for mild, intermittent asthma/respiratory disease.

Caregiver activities listed at this level include the administration of medications to children with asthma/respiratory disease (*RAD, BPD, PHTN*) on an as needed (PRN) basis. These medications may be administered by:

- Aerosol treatments that involve the delivery of sterilized water, normal saline (salt water) or medications by an electrically powered (or compressed-air/oxygen cylinder).
- The use of metered dose inhalers (MDI) which are hand held medication devices, or
- The use of oral bronchodilators on an as needed basis. The caregiver must be knowledgeable concerning when the child would benefit from this type of medication.

ASTHMA / RESPIRATORY DISEASE– LEVEL 2

Administration of daily medications for: Treatment of mild, persistent, moderate persistent and severe persistent asthma /respiratory disease.

OTHER CHRONIC RESPIRATORY CONDITION – LEVEL 2

POSTURAL DRAINAGE AND PERCUSSION UP TO THREE TIMES PER DAY:

Conditions that require postural drainage and percussion (PD & P) three or fewer times a day are in this category. Postural drainage and percussion is a therapy maneuver that helps the child cough up lung secretions. The child is positioned in various head-down positions (postural drainage) and often thumped or patted on the back (percussion) to further assist with secretion removal. The procedure usually takes 20-30 minutes. This procedure is commonly used with children who have the diagnosis of cystic fibrosis or bronchiectasis, but may also be used with any child with respiratory problems which interfere with the removal of lung secretions. The caregiver must receive special training in order to learn how to perform this procedure safely and effectively.

APNEA/HEART MONITOR: Children who must be monitored by an apnea (“lack-of-breathing”) or heart monitor also are considered at this level. The use of this equipment requires special training which is often given by both the hospital of discharge and the equipment rental company. The caregiver must be trained in how to deliver cardiopulmonary resuscitation (CPR) and must have a telephone in the home to call for emergency services in case the child stops breathing. The apnea/heart monitor is usually on the child continuously, but may be prescribed only for the hours the child is sleeping. All apnea/heart monitors frequently sound “false” alarms due to various problems (slipped monitoring band or electrodes, baseline alarm setting not calibrated to child’s condition, etc.), and are very stressful for the caregiver.

OTHER CHRONIC RESPIRATORY CONDITIONS - LEVEL 3

POSTURAL DRAINAGE AND PERCUSSION 4 + TIMES PER DAY: Children who require postural drainage and percussion (PD & P) four or more times a day are considered at this level. As previously detailed, PD & P is a therapy maneuver that helps the child cough up lung secretions. The child is positioned in various head-down positions (postural drainage) and often thumped or patted on the back (percussion) to further assist with secretion removal. The procedure usually takes 20-30 minutes.

INTERMITTENT USE OF OXYGEN: Included at this level are the activities required to care for children who require intermittent oxygen use. These children may require supplemental oxygen only during certain times of the day. Some children require oxygen during their hours of sleep, during feeding, or during stressful times such as bathing or dressing. Some children require oxygen during exertion only (play/work), and some children require oxygen only during times of respiratory distress (shortness of breath, wheezing, coughing, etc.). The caregiver must be alert to the needs of the child, and the oxygen equipment and supply of oxygen must be maintained in a ready state. Oxygen equipment is rented and the rental agency is responsible for periodically filling and servicing the equipment. The caregiver must alert the company when refills of the oxygen or repair of the equipment is needed.

OTHER CHRONIC RESPIRATORY CONDITIONS - LEVEL 4

CONTINUOUS OXYGEN: Activities at this level include caring for the child who requires continuous oxygen or mechanical ventilation. As mentioned under Level 3, the use of oxygen requires the caregiver to interact closely with the equipment rental agency, monitor the oxygen levels in the cylinders, and assure that an adequate supply of oxygen is available at all times.

VENTILATOR DEPENDENT: A child is ventilator dependent when he/she is unable to breathe effectively on his/her own, and requires the assistance of an electrically-powered machine to perform this function. The child must have a tracheostomy tube in order to receive this therapy on a continuous basis. Children who are ventilator dependent are often very critically ill, or so neurologically impaired that mechanical ventilation is usually considered a lifelong therapy.

TRACHEOSTOMY: Children who have tracheostomy tubes (tubes inserted through the neck into the windpipe) who require caregivers to suction periodically are considered at this level. Suctioning is done by using a suction catheter (tube) which is connected to an electrically-powered device. The catheter is inserted down the tube into the main airways of the lungs to suction out secretions that the child is unable to cough out on his/her own. Suctioning is a skill which requires that the caregiver be taught the proper procedure by hospital nursing personnel or visiting home nursing services. Risks due to airway damage (trauma during suctioning), infection, and airway blockage are always

present during this procedure. The caregiver also must be trained to reinsert the tracheostomy tube should it become dislodged or accidentally removed.

2-C MEDICAL AND DEVELOPMENTAL TREATMENT

MEDICAL TREATMENT – LEVEL 1

CONTROLLED SEIZURE DISORDERS WITH MEDICATION(S):

Caregivers who must care for children with controlled seizure disorders must be trained to administer first-aid and possible cardiopulmonary resuscitation (CPR). Seizures in children can be due to high fevers (usually disappearing around the ages of 3-4), neurological problems such as epilepsy or cerebral palsy, or past head trauma. The caregiver must make sure that the environment is made safe for the child should a seizure occur (e.g., padded bedrails or posts, carpeted bedrooms, protective headgear, etc.).

MEDICAL TREATMENT – LEVEL 2

Children with early onset of Type II Diabetes and their caregivers must be educated on the diabetic disease, treatment and the complications of uncontrolled diabetes. Diet, Oral Hypoglycemic Medication administration, urine and blood sugars must be monitored closely.

Administration of injectable medications for chronic conditions, i.e. Lovenox, Growth Stimulating Hormone.

MEDICAL TREATMENT - LEVEL 3

CAREGIVER ADMINISTRATION AND/OR SUPERVISION OF ADMINISTRATION OF FACTOR 8: Also considered at this level are children who require caregiver activities to supervise the administration of and/or administer the Factor 8 medication used by hemophiliacs to stop excessive bleeding from minor or major wounds. Caregivers must be vigilant to assure that the child receives the medication when needed, even after minor falls with possible bruising. The caregiver must make sure that a first-aid kit and adequate supplies are available at all times.

MEDICAL TREATMENT – LEVEL 4

NEWLY DIAGNOSED DIABETIC (DIAGNOSED WITHIN THE PAST SIX MONTHS):

Considered at this level are children with newly diagnosed diabetes. These children and their caregivers must rapidly learn how to cope with a chronic illness that requires diet control, frequent blood sugar testing, and the administration of oral and/or injectable medication several times a day. The child's blood sugar must be kept within a range prescribed by the physician to prevent hyperglycemia (high blood sugar) or hypoglycemia (low blood sugar) which can be a life threatening condition.

IV/CENTRAL VENOUS LINE: Children who require caregiver activities to administer medications through an intravenous (IV)/central venous line directly into the child's circulatory system are considered at this level. Children who have medication delivered in this manner are usually very ill and require close monitoring and supervision. Cancer and leukemia chemotherapy are usually administered in this manner. In many cases, visiting home nurses are responsible for the direct administration of medications through the IV line, but the caregiver must make sure that the line is kept patent (open) by periodically injecting an anticoagulant (anti-clotting) medication into the tubing. The child must be monitored closely for signs of possible infection, which could be quickly life-threatening if not treated promptly.

SEIZURE DISORDER NOT CONTROLLED BY MEDICATION: The child who takes anti-seizure medication, but continues to have seizures on a regular basis is considered at this level. The caregiver must be constantly vigilant for the child's safety, and must be sure that the child's environment is as safe as possible when seizures occur. The caregiver must be trained in first aid for seizures and in cardiopulmonary resuscitation (CPR).

Children who require the activities required by the caregiver to protect a child who has an uncontrolled seizure disorder are also considered at this level. These children have frequent (more than 1 time per day, or 4 per month) seizures, with at least one seizure each month that lasts greater than 5 minutes. Caregivers must be trained to administer first-aid and possible cardiopulmonary resuscitation (CPR), for all children who have seizure disorders, but who are more likely to use this procedure with the child who has seizures lasting greater than five minutes. Uncontrollable seizures in children are usually due to neurological problems such as epilepsy, cerebral palsy, or past head trauma, and are not fully controlled by preventive medications. The caregiver must assure that the environment is made safe for the child should a seizure occur (e.g., padded bedrails or posts, carpeted bedroom floors, etc.) and in many cases, the child must be made to wear protective headgear at all times.

DEVELOPMENTAL TREATMENT - LEVEL I

PRESCRIBED DEVELOPMENTAL TREATMENTS PROVIDED BY THE CAREGIVER:

Activities prescribed by the physician or a Regional Center to be performed by the caregiver on a daily basis are considered at this level. Infant stimulation procedures, and physical, occupational and speech therapies are all applicable at this level. These therapies may be ordered for the infant/child who was born severely premature (28-32 weeks), or for the child who was born prenatally drug-exposed. Infant stimulation may be required for the premature or developmentally delayed infant who has slowed reflexes and needs stimulation in order to facilitate movement and normal muscle development. Speech, occupational, and physical therapy may be prescribed by the physician or Regional Center. The caregiver may be asked to perform such ordered therapies specifically designed for the child to help him/her develop skills required for optimum development.

In order to qualify for F-rate reimbursement, these therapies must be prescribed by a physician or Regional Center, and the caregiver must complete special training in order to perform these in-home services.

3. Monitoring Health Status of the Child

Once an infant/child is documented to be un-infected, the specialized care rate no longer applies.

Considered in this category is the specialized care required for children with or at risk of life-threatening illness/disease that may be communicable or non-communicable. These illnesses include but are not limited to HIV/Aids, Hepatitis B, Hepatitis C, sickle cell disease (not trait), tuberculosis, cancer, organ transplant, etc.

3-A POTENTIALLY LIFE-THREATENING NON- COMMUNICABLE DISEASE/ILLNESS

ADMINISTRATION AND/OR SUPERVISION OF SPECIFIC MEDICATIONS FOR POTENTIALLY LIFE THREATENING CONDITIONS - LEVEL 3

Children with cardiac problems or other serious conditions where the administration of medication requires specific monitoring skills. These skills may include taking pulse or blood pressure, or other observations as directed by a physician. The caregiver keeps a written record and consults with the physician according to a written protocol.

SERIOUS ILLNESS IN REMISSION: Also considered at this level are the caregiver activities required for a child whose serious condition is in documented remission, but where the caregiver must continue vigilant monitoring of the child's health status due to high risk of relapse.

DAILY MONITORING - LEVEL 4

Caregiver activities include closely monitoring the child's vital signs (respiratory rate, heart rate, blood pressure, level of consciousness), watching for signs of organ rejection, or dealing with multiple, life threatening problems are considered at this level. Included are the care of children who have leukemia or other diseases such as sickle cell disease, aplastic anemia, or immune deficiency disorders that require an intense level of care. The caregiver must be knowledgeable concerning the child's disease and educated to the monitoring processes necessary to assure that the child receives prompt medical care for any potential problem.

REVERSE PRECAUTIONS: Also included at this level are caregiver activities which may be required to prevent the spread of infection to a child who may have a weakened immune system due to disease states (immune disorders, bone marrow transplants, chemotherapy, etc.) Precautions such as limiting visitation from friends and other children, prohibiting visits to the mall or supermarket with the child, and frequent hand washing for all family members are often required and may significantly impact family functioning.

3-B POTENTIALLY LIFE-THREATENING COMMUNICABLE ILLNESS/DISEASE

POTENTIALLY LIFE-THREATENING COMMUNICABLE ILLNESS/ DISEASE LEVEL 1

Considered at this level are specialized care activities for children who are prescribed medication that must be administered for a six month period of time or longer to prevent communicable disease, such as M. Tuberculosis prophylaxis. Caregiver activities are expected to include some form of monitoring as well as follow up medical visits.

UNIVERSAL PRECAUTIONS ESSENTIAL - LEVEL 3

Considered at level 3 are those caregiver activities necessary to practice strict universal precautions to protect themselves and others from life-threatening illness. Caring for children with chronic Hepatitis B and/or Hepatitis C is included in this level. Another communicable disease that may cause severe infections is the newborn and pose a risk to some family members is cytomegalovirus (CMV) infection.

DRUG RESISTANT INFECTIONS: Included at this level are caregiver activities related to the child with a drug resistant infection, where the caregiver must insure strict adherence to a prolonged medical regimen. Drug resistant illness, ie. MRSA, ORSA.

POTENTIALLY LIFE-THREATENING COMMUNICABLE ILLNESS/DISEASE LEVEL 4

Included at this level are caregiver activities required for the infant or child with an HIV positive blood test. These include strict universal precautions, frequent medical appointment, complex medication regimens, “reverse precautions”, etc. (reverse precautions are those activities which may be required to prevent the spread of infections to a child who may have a weakened immune system due to illness states [immune disorders, bone marrow transplants, chemotherapy, etc.] Precautions such as limiting visitation from friends and other children, prohibiting visits to the mall or supermarket with the child, and protecting the child from common illnesses such as colds and flu, are often required and may significantly impact family functioning.)

4. CARING FOR INFANT PRENATALLY-EXPOSED TO DRUGS/ALCOHOL

Prenatal drug exposure may be diagnosed early in a child by a positive drug-screen in either the infant or the mother, or by symptoms of prenatal drug-exposure manifested by the infant at birth. Infants who are prenatally drug-exposed may show early symptoms which require specific caregiver interventions.

4-A COPING WITH PRENATALLY DRUG-EXPOSED INFANT BEHAVIORS

Infants/children (0-2 years old) who were prenatally exposed to drugs may, or may not, show symptoms of this exposure. Early (newborn/infant) symptoms that could be caused by prenatal drug-exposure include irritability, arching of the back, rigidity (stiffness) or flaccid muscles, poor sucking reflex, or refusal to make eye contact. The older drug-exposed child may also exhibit these same symptoms, usually to a lesser degree, and may also show signs of slow speech development and other developmental delays. Probably the most difficult symptom for the caregiver to cope with is the extreme irritability that may be seen in some of these infants/children. For that reason, this symptom is used to guide the assessment of the appropriate F-rate level for the caregiver.

PRENATALLY-EXPOSED TO DRUGS/ALCOHOL - LEVEL 1

CRYING UP TO 6 HOURS/DAY: Infants/children who require caregiver activities involved in calming an infant/child with inconsolable crying and high-pitched screaming which lasts up to six hours a day are considered at this level. caring for an infant/child who cries to this degree is stressful for the caregiver and the family system.

PRENATALLY-EXPOSED TO DRUGS/ALCOHOL - LEVEL 2

CRYING 6 TO 12 HOURS/DAY: Children who require caregiver activities involved in calming an infant/child with inconsolable crying and high-pitched screaming which lasts up to 12 hours a day are considered at this level. Caring for a infant/child who cries to this degree is very stressful for the caregiver and the family system.

PRENATALLY-EXPOSED TO DRUGS/ALCOHOL - LEVEL 3

CRYING MORE THAN 12 HOURS/DAY: Children who require caregiver activities involved in calming an infant/child with inconsolable crying and high-pitched screaming which lasts more than 12 hours a day are considered at this level. Caring for an infant/child who cries to this degree is extremely stressful for the caregiver and the family system.

5. CARING FOR CHILDREN WITH DEVELOPMENTAL DISABILITIES

This category is for those children who have received a diagnosis of a developmental disability from a Regional Center. These children will receive the appropriate Regional Center rate if receiving Regional Center services unless child is eligible for a higher F-rate (i. e. child is 0 – 3 years old, receiving Early Start services but not yet determined to have a qualifying developmental disability and has a medical/physical condition that warrants an F-2, F-3 or F-4 rate)

5-A DISABILITIES

Children who have been diagnosed by or are receiving services from Regional Centers for developmental disabilities are considered in this category. If the child was diagnosed by a private provider or agency, a confirming diagnosis must be obtained by a Regional Center. The following levels are based upon diagnoses as given by the Regional Centers but does not determine the F-rate as the Regional Center rates have already been set as follows:

- \$2,006.00/month for the care and supervision of children served by dual agencies three years of age and older.
- \$898.00/month for children under the age of three years who receive services under California's Early Start Intervention Services Act, **but are not yet determined** to have a developmental disability and who receive AFDC-FC or AAP benefits.
- If a regional center subsequently determines that a child under three years of age is an individual with a developmental disability, the rate to be paid from the date of that determination is \$2,006/month.

- An additional supplemental rate of up to \$1,000.00/month for those children **three years and older** served by dual agencies determined to have extraordinary care and supervision needs. There is a separate process to determine the appropriate amount for the supplemental rate.

Note: Regional Center identifies children, with mental retardation and under age three as “developmentally delayed” until more thorough testing can be performed.

DEVELOPMENTAL DISABILITIES - LEVEL 1

Children who have the following Regional Center diagnoses are considered at this level:

- Developmentally Delayed (under age 3)
- Mild Mental Retardation (age 3 or older)
- Epilepsy/Seizure Disorder
- Mild/Moderate Cerebral Palsy

DEVELOPMENTAL DISABILITIES - LEVEL 2

Children who have the following Regional Center diagnoses are considered at this level:

- Moderate Mental Retardation
- Autism - mild

DEVELOPMENTAL DISABILITIES - LEVEL 3

Children who have the following Regional Center diagnoses are considered at this level:

- Severe Mental Retardation
- Autism - moderate
- Severe Cerebral Palsy (significantly impairs activity)

DEVELOPMENTAL DISABILITIES - LEVEL 4

Children who have the following Regional Center diagnoses are considered at this level:

- Profound Mental Retardation
- Severe Cerebral Palsy (significantly impairs activity)
- Autism - full syndrome

6A WORKING WITH A CHILD’S BEHAVIOR PROBLEMS IN CONJUNCTION WITH MEDICAL PROBLEMS

Caring for an infant or child with a medical problem is especially difficult when the child also has an emotional or behavioral problem which interferes with rendering prescribed medical care. To be considered in this category, the child must be age 3 or older, have

a documented emotional/behavioral problem, and be enrolled in **and** attending a treatment program designed to address the emotional/behavioral problem diagnosed. This category was added to recognize the many challenges associated in caring for the medically-needy child with emotional/behavioral problems, and increases the F-rate by one level beyond the highest medically-related activity required to be delivered by the caregiver.

6B WHEN A CHILD HAS MULTIPLE MEDICAL PROBLEMS: that require the caregiver to attend multiple appointments, administer multiple treatments, or visit multiple specialists, consideration may be given to increase the rate one level above the highest medically related caregiver activity - up to level four. Specific caregiver tasks need to be documented by the healthcare provider(s).



PHILIP L. BROWNING
Interim Director

**County of Los Angeles
Department of Children and Family Services**

425 Shatto Place, Los Angeles, CA 90020
(213) 351-5602

Date:

Please address reply to:

MEDICAL CARE ASSESSMENT COVER LETTER

RE: Child's Name: _____
State Number: _____
Date of Birth _____
Caregiver: _____

Dear _____,

We understand that you recently examined the above named child who is in foster placement with the Los Angeles County Department of Children and Family Services.

Before we can authorize a specialized foster care rate of reimbursement to the care required because of the child's diagnosed condition(s), it is necessary for us to obtain additional information.

Please complete either the attached "Medical Care Assessment" form or send a copy of your medical records or a dictated report that contains the requested information. Please send this information to the child's social worker (CSW) named on the attached form. Your prompt attention to this matter will enable us to quickly and responsibly compensate the caregiver for their much needed services.

If you require additional information, please call me at: _____

My return fax number is: _____.

Very truly yours,

Children's Social Worker

MEDICAL CARE ASSESSMENT**TO:**

File # _____

RE:

(Child's Name) _____

Social Worker's Phone _____

Medical Record # _____

Social Worker's Fax # _____

Birth Date: _____

I examined the above mentioned child on _____. The following information summarizes the child's diagnosis, treatment required, and special care activities I have prescribed for the child.

CHILD'S DIAGNOSIS:**DATE OF DX:**

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

CHILD'S PROGNOSIS:**MEDICATION/TREATMENT REQUIRED****FREQUENCY****EXPECTED DURATION**

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

How often is medical follow up needed? _____

Please list all specific activities Foster Parent must perform to implement your care plan:

Physician's Signature

Specialty: _____

Date Signed: _____

Physician Name (Please Print)

Address: _____

Phone #: _____

Fax #: _____



Individual Health Care Plan (IHCP)

Check type of IHCP: ☐ Initial ☐ Six Month Reassessment

Referent: _____ Phone No.: _____
 Case _____ Case No.: _____
 Child's _____ DO _____ Sex: ____ Prim. _____
 CSW _____ Phone No.: _____
 Location of _____ Legal Status _____
 Reason for Medical Placement _____

Describe child's special health care needs (If applicable, attach hospital discharge plan. Note six month _____

Individual Health Care Plan Team (Place Asterisk in front of designated Health Care
 Hospital _____ Phone No.: _____
 Doctor(s) _____ Phone No.: _____
 Hospital Social _____ Phone No.: _____
 Other(s) _____ Phone No.: _____
 Foster Parent's (FP) _____ FP's Phone _____
 FP's _____ Current Foster Care
 Address: _____ Rate: _____

Check Type of Foster Care:

- | | |
|---|---|
| <input type="checkbox"/> Foster Family Agency | <input type="checkbox"/> Foster Family Home (FFH) |
| <input type="checkbox"/> Intermediate Care Facility (ICF) | <input type="checkbox"/> Small Family Home (SFH) |
| <input type="checkbox"/> Skilled Nursing Facility (SNF) | Licensed Capacity: _____ |
| <input type="checkbox"/> Other: _____ | |

Describe specialized in-home health care to be provided by foster parent.

Date Foster Parent (FP) completed training to meet health care needs of child (Attach copy of documentation of _____)

Trainer: _____

Phone No.: _____

Date child placed with FP: _____

Is the current specialized foster care rate for child appropriate to ensure child's health care
☐ Yes ☐ No If NO, _____

And recommend rate _____ or decrease _____

If foster care resource is a FFH, identify any other special health care child(ren) in FFH home IHCP Coordinator (only two special health care children can be placed in a FFH unless third criteria is met and documented in case record).

1) _____ IHCP Coord.: _____ Phone _____

2) _____ IHCP Coord.: _____ Phone _____

Identify available and funded Medical Resources to meet child's special health care needs:

Describe Child Welfare Service Plan (Include Social, Emotional, Mental and Functional skill when doing six month re-assessment)

Next six month reassessment due _____

Completed _____ Title: _____ Date: _____

F- RATE INDICATORS

CSW please complete for children with medical conditions, physical disabilities, and/or developmental delays then consult with PHN
Consult with MCMS (Medical Case Management Services) for all F-rated cases

Forward a 149A to the appropriate CCS paneled and/or appropriate pediatric specialty treating physician(s) and request they complete the form and return it along with all available medical records documenting the child's status and needs.

Child's Name: _____ DOB: _____ Date Completed: _____

Age of Child: _____ Social Security # _____ Date of Initial _____

CSW Name & File No: _____ Phone _____

Funding type: ☐ Foster Care/Youakim ☐ AAP ☐ CAL Works/TANF(AFDC) ☐ SSI ☐ None
☐ Kin GAP
☐ FFA Rate (specialized rate assessment should occur when adoption plan is activated (i.e.: home study is started or case referred to PRU for matching).

Current Rate: ☐ Basic Rate ☐ D rate ☐ F1 rate ☐ F2 rate ☐ F3 rate ☐ F4 rate

☐ Dual Agency Rate \$ _____ + supplement _____ = _____

Date of last Rate Assessment _____

For any box checked on this page, fill out the corresponding numbered section on pages 2, 3 or 4. Then complete the "Actions to be Taken" section on page 5.

CHILD WILL RECEIVE APPROPRIATE DUAL AGENCY RATE IF ELIGIBLE FOR REGIONAL CENTER SERVICES
UNLESS CHILD IS ELIGIBLE FOR A HIGHER F-RATE (i. e. children age 0-3 receiving Regional Center Early Start
Services shall receive the "under 3" Dual Agency rate of \$898/month unless qualifying for a higher F-rate (ie F2, F3, F4)

Physical / Medical – F Rate		Developmental Delay – F Rate Rate	
1. <input type="checkbox"/>	Asthma/Respiratory Problems/ Apnea Monitor	18. <input type="checkbox"/>	Child age 0-3 with Developmental Delay (in Regional Center Early Start Program eligible for \$898 dual agency rate) but who may be eligible for F2, F3 or F4 rate
2. <input type="checkbox"/>	Seizures	19. <input type="checkbox"/>	Mental Retardation
3. <input type="checkbox"/>	Prenatal Drug/Alcohol Exposure	20. <input type="checkbox"/>	Autism
4. <input type="checkbox"/>	Vision or Hearing Problems	21. <input type="checkbox"/>	Cerebral Palsy
5. <input type="checkbox"/>	Ambulation	22. <input type="checkbox"/>	Children with Epilepsy/Seizure Disorder
6. <input type="checkbox"/>	Bladder/Bowel Control Problem (not age appropriate)	23. <input type="checkbox"/>	Speech Delay or Disorder
7. <input type="checkbox"/>	Hygiene Problem	24. <input type="checkbox"/>	Dual Agency Rate
8. <input type="checkbox"/>	Feeding/ Eating Difficulty/Special Diet/Food Allergies	a. <input type="checkbox"/>	Child age 0-3 with Developmental Delay (in Regional Center Early Start Program) – child does not qualify for F2, F3 or F4 rate
9. <input type="checkbox"/>	Children who require Developmental therapy	b. <input type="checkbox"/>	Child age 0-3 eligible for regional center services with diagnosed permanent developmental disability
10. <input type="checkbox"/>	Surgical/ Wound Care/Artificial Limb	c. <input type="checkbox"/>	Child age 3 or older eligible for regional center
11. <input type="checkbox"/>	Diabetes		(See Policy # 0900-511.12 Regional Center Foster Rates for Dual Agency Children if box a,b,c is checked)
12. <input type="checkbox"/>	Hemophilia		
13. <input type="checkbox"/>	IV/Central line		
14. <input type="checkbox"/>	Life threatening illness requiring strict monitoring for communicable/non-communicable diseases.		
15. <input type="checkbox"/>	Medical Treatment		

Physical / Medical – F Rate		Developmental Delay – F Rate Rate	
16. <input type="checkbox"/>	A) Emotional/Behavioral problem in addition to other F-rate condition		
<input type="checkbox"/>	B) Multiple medical problems requiring multiple appointments, treatment, specialists etc.		
17. <input type="checkbox"/>	Other		

PHYSICAL/MEDICAL PROBLEMS WHICH MAY QUALIFY CHILDREN FOR THE F RATE1. ☐ **Asthma/Chronic Respiratory Problems**

<input type="checkbox"/> F1	- As needed medication/treatment supervised by caregiver
<input type="checkbox"/> F2	- Daily medication/treatment supervised by caregiver; or - Use of apnea or heart monitor (MUST BE CPR TRAINED); or - Postural drainage and percussion required up to 3 times per day
<input type="checkbox"/> F3	- Use of intermittent oxygen; or Postural drainage and percussion required 4 or more times a day
<input type="checkbox"/> F4	- Use of continuous oxygen or ventilator dependent; or Tracheostomy

2. ☐ **Seizures**

<input type="checkbox"/> F1	- Controlled seizure disorder with medication(s)
<input type="checkbox"/> F4	- Uncontrolled seizure disorder

3. ☐ **Prenatal Drug Exposure**

<input type="checkbox"/> F1	- Inconsolable crying/screaming up to 6 hours a day
<input type="checkbox"/> F2	- Inconsolable crying/screaming up to 6 - 12 hours a day
<input type="checkbox"/> F3	- Inconsolable crying/screaming over 12 hours a day

4. ☐ **Vision / Hearing Problems**

<input type="checkbox"/> F1	- Eye Prosthesis
<input type="checkbox"/> F2	- Legally blind or hearing impaired
<input type="checkbox"/> F4	- Totally blind and/or profoundly deaf

5. ☐ **Ambulation**

<input type="checkbox"/> F1	- Over 2 years old, child requires prescribed orthopedic corrective devices, e.g. ankle. foot, orthotics that are time limited.
<input type="checkbox"/> F4	- Over 2 years old, child requires wheelchair, gurney, leg braces, walker, etc. Any age with extensive casting

6. ☐ **Elimination (Bladder or Bowel Control Problem)**

- The conditions below may indicate a developmental delay; consider whether referral to Regional Center is appropriate.
- The condition below may also be a sign of an emotional/behavioral problem, consider whether a referral for a psychological evaluation would be appropriate.

<input type="checkbox"/> F1	- 4 and older, not toilet trained due to medical problem nighttime enuresis/encopresis
<input type="checkbox"/> F2	- 4 and older with no bladder and/or bowel control day and night due to a medical problem
<input type="checkbox"/> F3	- Child requires use of appliance such as a colostomy bag or catheter tubes
<input type="checkbox"/> F4	- Child has kidney disorder requiring dialysis

7. ☐ **Hygiene Problem**

- The conditions below can indicate a developmental delay, consider where referral to Regional Center is appropriate

<input type="checkbox"/> F1	- Child age 4 – 7 assistance with hygiene such as bathing, dressing etc., non-extensive cast care, one extremity
<input type="checkbox"/> F2	- Child age 8 and older unable to bath, dress, etc. unassisted due to a medical problem

8. ☐ **Feeding/Eating Difficulty**

<input type="checkbox"/> F1	- Infants/children who need 30 – 60 minutes to feed due to a medical problem, E.G. GERD; or - Children who need supervised self feeding due to a medical problem e.g. C.P or Down syndrome
<input type="checkbox"/> F2	- Infants or children who require feeding time over 60 minutes due to a medical problem; or - Children who cannot self-feed DUE TO A MEDICAL PROBLEM or - Children who require a special diet (e.g. Due to diabetes or kidney problems) or intense monitoring e.g. Caring for a failure to thrive child (FTT).
<input type="checkbox"/> F3	- Children who require intermittent G-tube feeding, SPECIAL FEEDING; or - Children who need a special diet requiring strict diet planning; or - Children who have a documented severe food allergy requiring an EPI(nephren)-PEN
<input type="checkbox"/> F4	- Children who require continuous G-tube feeding; or - Children who need feeding through NG (nose) tube; or - Children who require parenteral nutrition

9. ☐ **Children who Require Developmental Therapy**

<input type="checkbox"/> F1	- Caregiver performs prescribed infant stimulation, physical, occupational or speech therapy See attachment II for specific qualifiers
-----------------------------	--

10. ☐ **Surgical/Wound Care/Artificial Limb**

<input type="checkbox"/> F2	- Established cerebral shunt care; or - Established prosthetic or missing appendage
<input type="checkbox"/> F3	- New or revised shunt care (first 6 months after insertion or revision) Daily/Frequent dressing changes
<input type="checkbox"/> F4	- Post multi-stage surgical care e.g. burn reconstruction

11. ☐ **Diabetes**

<input type="checkbox"/> F2	- Treatment of type II diabetes with oral hypoglycemic medications
<input type="checkbox"/> F3	- Caregiver administration/supervision of insulin dependent/type I diabetic child
<input type="checkbox"/> F4	- Newly diagnosed insulin dependent/type I diabetic child. (within the last 6 months)

12. ☐ **Hemophilia**

<input type="checkbox"/> F3	- Caregiver administration/supervision of Factor 8 treatment.
-----------------------------	---

13. ☐ **IV/Central Line**

<input type="checkbox"/> F4	- Medication/chemotherapy is administered through an IV or central line
-----------------------------	---

14. ☐ **Life threatening illness requiring strict monitoring for communicable/non communicable diseases**

<input type="checkbox"/> F1	- Prophylactic medications for tuberculosis.
<input type="checkbox"/> F3	- Documented remission of disease; or - Caregiver administration/supervision of medications for potentially life threatening illness, e.g. cardiac conditions; or - Universal precautions needed for illnesses Hepatitis B,C;or - Drug resistant conditions requiring strict medication regimen.
<input type="checkbox"/> F4	- Daily monitoring required, e.g. organ transplant, aplastic anemia, immune deficiency disorder, cancer, leukemia, etc.; or - Also for reverse precautions.; or - HIV/AIDS positive blood test. See attachment II for specific qualifiers

15. ☐ **Medical Treatment**

<input type="checkbox"/> Level 1	- Administration of topical medications for severe/chronic conditions, e.g. eczema.
<input type="checkbox"/> Level 2	- Administration of injectable medication for chronic conditions

16. ☐ **A) Children Who Have an Emotional Behavioral Problem in Addition to One or More of the Conditions Listed Above**

First consider if the child's emotional/behavioral problems are severe enough to qualify for the D rate

- ☐ Increase F Rate by 1 level If the child is receiving an F rate for any of the conditions described above and has a documented emotional/behavioral problem
- Criteria:**
- Child must be 3 or older and enrolled in and attending a treatment program
 - Foster Care Payments: emotional/behavioral problem must be documented by the Department of Mental Health.
 - AAP Payments: documentation is not required to be from Department of Mental Health; documentation may be from any psychologist/psychiatrist.

☐ **B) Children with multiple medical conditions requiring the caregiver to attend multiple appointments, administer multiple treatments or visit multiple specialists. Consideration may be given to increase the rate one level above the highest medically related activity up to level 4**

17. ☐ **Other**

Indicate any other physical/medical problems the child has below. See your Supervisor and Public Health Nurse to discuss services and/or funding that might be available for the child based on this condition.

Attach additional pages if necessary to provide additional information about the child's condition and specialized care activities to be provided by the caregiver.

Rates for Children with Developmental Disabilities

CHILD WILL RECEIVE THE APPROPRIATE DUAL AGENCY RATE IF RECEIVING REGIONAL CENTER SERVICES UNLESS CHILD IS ELIGIBLE FOR A HIGHER F-RATE (i. e. child is 0 – 3 years old, receiving Early Start services and not yet determined to have a qualifying developmental disability, but has a medical/physical condition that warrants an F-2, F-3 or F-4 rate)

18. ☐ Children Age 0-3 with Developmental Delay (diagnosis must be completed by Regional Center)
- | |
|---|
| <input type="checkbox"/> Level Children age 0-3 receive Regional Center Early Start Services shall receive the “under 3” Dual Agency rate of \$898/ month unless they qualify for a higher F rate (ie F2, F3 or F4) or unless their disability is diagnosed by Regional Center as permanent prior to age 3 in which case they shall receive the Dual Agency rate of \$2006. |
|---|
19. ☐ Children who are diagnosed with mental retardation (diagnosis must be completed by Regional Center)
- | |
|--|
| <input type="checkbox"/> Level 1 - Children age 3 and older with mild mental retardation |
| <input type="checkbox"/> Level 2 - Children with moderate mental retardation |
| <input type="checkbox"/> Level 3 - Children with severe mental retardation |
| <input type="checkbox"/> Level 4 - Children with profound mental retardation |
20. ☐ Children who are Autistic (diagnosis must be completed by Regional Center)
- | |
|---|
| <input type="checkbox"/> Level 2 - Children with mild autism |
| <input type="checkbox"/> Level 3 - Children with moderate autism |
| <input type="checkbox"/> Level 4 - Children with full syndrome autism |
21. ☐ Children with Cerebral Palsy (diagnosis must be completed by Regional Center)
- | |
|---|
| <input type="checkbox"/> Level 1 - Children with mild to moderate cerebral palsy |
| <input type="checkbox"/> Level 3 - Children with severe cerebral palsy (significantly impairs activity) |
| <input type="checkbox"/> Level 4 - Children with severe cerebral palsy which precludes activity (significantly impairs) |
22. ☐ Children with Epilepsy/Seizure Disorder (diagnosis must be completed by Regional Center)
- also see “Seizures” section under Physical/Medical Problems Which Qualify Children for the F rate
- | |
|--|
| <input type="checkbox"/> Level 1 - Epilepsy/seizure disorder |
|--|
23. ☐ Children with Speech Delay or Disorder and **NOT** receiving Regional Center Services
- | |
|--|
| <input type="checkbox"/> Level 1 Caregiver is prescribed by physician or Regional Center to perform speech therapy |
|--|

24. ☐ **Dual Agency Rate and Supplement**

REMINDER

- a. Child 0-3 with Developmental Delay (in Regional Center Early Start Program) – child does not qualify for F2, F3 or F4 rate
 - o “under 3 “ Dual Agency Rate of \$898
- b. Child 0-3 eligible for regional center services with a diagnosed permanent developmental disability
 - o Dual Agency Rate of \$2,006. Children under 3 do not qualify for Dual Agency Supplement
- c. Child age 3 and older eligible for regional center services
 - o Dual Agency Rate of \$2006. Additionally, the child may qualify for Supplement of \$250, \$500, 750 or \$1,000) depending on the special needs of the child.

See Policy # 0900-511.12 Regional Center Foster Rates for Dual Agency Children

Actions To Be Taken

Attach supporting documentation such as physician's diagnosis, prognoses and treatment plan, psychological evaluation, and specialized care activities to be provided by caregiver.

Caregiver and Child Qualification Section *(to be completed by CSW)*

- ☐ Caregiver needs specific instructions and/or training on the child's medical condition. Describe below the training needed, who (i.e. Regional Center, the pediatrician etc.) will provide training, referrals the CSW will provide, and when training will occur.
Attach additional pages if necessary.

Caregiver has completed F-rate training ☐ YES ☐ NO Certificate Date _____ Training Certificate attached
☐ YES ☐ NO Reason: _____

Caregiver and back-up caregiver have completed child-specific training for child's medical/developmental problems
☐ YES ☐ NO
Training certificate attached ☐ YES ☐ NO. Reason: _____

Child meets the criteria for specialized health care needs (see policy #0600.505.10). ☐ YES ☐ NO
If YES, does caregiver's home meet the criteria? ☐ YES ☐ NO. If No, describe steps that will be taken.

PHN F-Rate Recommendations: According to available information this child's level of care appears to meet criteria for (check one):

- ☐ F1 ☐ F2 ☐ F3 ☐ F4 Date of diagnosis _____ (attach documentation)
☐ This child's level of care does not appear to meet the criteria for a Specialized Care F-rate.

Additional PHN Recommendations:

- ☐ Recommend transfer to MCMS
☐ Recommend F-rate be re-evaluated in _____ months
☐ No F-rate training documentation is attached. F-rate training or F-rate renewal training appears to be needed by caregiver.
☐ No child-specific medical training documentation is attached. Child specific medical training appears to be needed by caregiver.

Signature of PHN: _____

Date: _____

CSW Actions – According to available information, this child's level of care appears to meet criteria for the rate listed below: (check one) ☐ F1 ☐ F2 ☐ F3 ☐ F4 _____ /month for child. Effective Date _____

☐ Request retroactive payments. Date of diagnosis: _____ (attach documentation).

☐ Refer child for additional services/evaluations (list) _____

☐ Current rate ☐ F1 ☐ F2 ☐ F3 ☐ F4 ☐ Dual Agency Rate of \$ _____ + supplement effective date _____

☐ Basic rate appears to be appropriate. This child's level of care does not meet the criteria for a Specialized Care Rate

Rate Review Requirements:

The next review to see if child's condition has changed and to reevaluate the current foster care rate will be: **Date:** _____

For AAP the rate is re-certified every 2 years. The next re-certification date is **Date:** _____

Caregiver's Agreement (complete this section only if the F rate has been approved)Rate will be (check one and fill in amount per month) ☐ F1 ☐ F2 ☐ F3 ☐ F4

I understand that the amount and duration of the F-rate is subject to review at least every six months (every two years for AAP). The review may result in a change in the F-rate status for the child, i.e. increase, decrease, termination of payment and that I will receive a Notice of Action letter from DCFS if any such changes take place.

Caregiver's

Signature: _____ Date: _____

Signature of CSW: _____ Date: _____

Signature of SCSW: _____ Date: _____

ARA and RA signatures are required for F3 or F4 rates

Signature of ARA _____ Date: _____

Signature of RA _____ Date: _____
Rate of

Approval of F ____ \$ ____ per month: